# MEDICARE ANNUAL REPORT TO THE CONGRESS

## Fiscal Year 1987

Including Reports on the:

- Medicare Validation Surveys of Hospitals Accredited by the Joint Commission of Accreditation of Health Care Organizations
- Medigap Voluntary Certification Program

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U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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# INTRODUCTION

Medicare is a Federal health insurance program administered by the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services (HHS) for people 65 or older, certain younger disabled people, and people of any age with permanent kidney failure.

Enacted into law in July 1965 and inaugurated a year later, Medicare has two parts: hospital insurance (Part A) and supplementary medical insurance (Part B). Hospital insurance helps pay for medically necessary care provided by a Medicare-approved hospital, skilled nursing facility, home health agency, or hospice program. Medical insurance helps pay for medically necessary doctor services, outpatient hospital services, certain home health care, and various medical services and supplies not covered by Medicare hospital insurance. Hospital insurance is financed through the Federal Insurance Contributions Act (FICA) tax paid by employees, employers and the self-employed. Medical insurance, which is voluntary, is financed from the monthly premiums paid by enrollees and from Federal general revenues.

Payments for services and supplies provided to Medicare beneficiaries are made through private insurance organizations under contract with the Federal Government. Hospital insurance claims are handled by Medicare "intermediaries," and medical insurance claims by Medicare "carriers."

Medicare outlays are reflected in the national health expenditures which, in calendar year 1987, topped $500 billion, an increase of 9.8 percent from 1986. Medicare benefit outlays totaled $79.75 billion in fiscal year (FY) 1987, an increase of 7.7 percent or 2.1 percent less than the rate of increase for all health expenditures. Medicare accounted for 18 percent of all personal health care expenses in the country in calendar year 1987, including 27 percent of all hospital bills and 22 percent of all payments for physician services. National health expenditures, as a share of the gross national product, continued its upward climb to 11.1 percent in 1987, increasing from 10.7 percent in 1986 and nearly double what it was in 1965. Per capita spending increased to a level of $1,987, or almost 10 times the per capita spending of 1965.

This report summarizes Medicare activity and HCFA's initiatives during FY 1987.

## ABBREVIATIONS USED IN THIS REPORT

AAPCC ..... Adjusted average per capita cost
AIDS ..... Acquired immune deficiency syndrome
ALICO ..... Amalgamated Life Insurance Company of America
ALJ ..... Administrative law judge
APACHE ..... Acute physiology and chronic health evaluations
ASC ..... Ambulatory surgery center
ATB ..... All trunks busy
AVG ..... Ambulatory visit group
BEA ..... Bureau of Economic Analysis
BITS ..... Beneficiary Inquiry Tracking System
CABG ..... Coronary artery bypass grafts
CAP ..... College of American Pathologists
CDRGs ..... Children's diagnosis related groups
CMP ..... Competitive medical plan
COBRA ..... Consolidated Omnibus Budget Reconciliation Act of 1985
CPEP ..... Contractor performance evaluation program
CPT ..... Claims processing timeliness
CWF ..... Common working file
DCG ..... Diagnostic cost group
DEFRA ..... Deficit Reduction Act
DOJ ..... U.S. Department of Justice
DOLA ..... Delegation of leasing authority
DRG ..... Diagnosis related group
EAP ..... Employee Assistance Program
EMC ..... Electronic media claim
ESRD ..... End-stage renal disease
FSES ..... Fire Safety Evaluation System
FY ..... Fiscal year
GHPS ..... Group health plan system
GNP ..... Gross National Product
HCFA ..... Health Care Financing Administration
HHA ..... Home health agency
HHS ..... U.S. Department of Health and Human Services
HI ..... Hospital Insurance Trust Fund
HMO ..... Health maintenance organization
ICF ..... Intermediate care facility
ICR ..... Internal Control Review
ICN ..... Inventory control number
IMC ..... International Medical Centers
JCAHO ..... Joint Commission on Accreditation of Healthcare Organizations
LGHPs ..... Large group health plans
LSC ..... Life Safety Code

MAAC ..... Maximum allowable actual charge
MIGs ..... Medicare insured groups
MSP ..... Medicare Secondary Payer Program
NAIC ..... National Association of Insurance Commissioners
NIH ..... National Institutes of Health
NTIS ..... National Technical Information Services
OBRA ..... Omnibus Budget Reconciliation Act
OIG ..... Office of Inspector General
OMB ..... Office of Management and Budget
OPA ..... Office of Public Affairs
ORD ..... Office of Research and Demonstrations
PHS ..... Public Health Service
PIP ..... Periodic interim payment
P.L. ..... Public law
PMI ..... Presidential management intern
PPS ..... Prospective payment system
PRO ..... Peer review organization
ProPAC ..... Prospective Payment Assessment Commission
QRO ..... Quality review organization
R&D ..... Research and demonstrations
RDES ..... Regional Data Exchange System
ROE ..... Return on equity
SA ..... State agencies
S/HMO ..... Social/health maintenance organization
SMI ..... Supplementary Medical Insurance Trust Fund
SNF ..... Skilled nursing facility
SSA ..... Social Security Administration
TEFRA ..... Tax Equity and Fiscal Responsibility Act
TURPS ..... Transurethal resection prostatectomies

# EXECUTIVE SUMMARY

## MEDICARE POPULATION AND BENEFITS

### Beneficiaries

During FY 1987 the number of Medicare beneficiaries increased by approximately 661,000, from 31.75 million to 32.41 million (Tables 1 and 2). About 589,000 of the new beneficiaries were 65 years of age and older, bringing to 29.38 million the number of elderly enrolled in Medicare; 72,000 were younger disabled persons, boosting the number of disabled beneficiaries to 3.03 million. Of the total number of beneficiaries, 31.738 million were residents of the United States, 418,000 lived in U.S. commonwealths and territories, and 255,000 resided in other countries.

Nearly 95 percent (27.8 million) of the aged and 92 percent (2.8 million) of the disabled were enrolled in both Medicare Hospital Insurance (Part A) and Medicare Supplementary Medical Insurance (Part B). Approximately 96 percent of the Medicare enrollees residing in the 50 states and the District of Columbia were covered by both parts (Table 3).

### Health Care Providers

At the close of the fiscal year, 5,895 short-stay and 278 long-stay hospitals with about 1.17 million beds were participating in Medicare, as were 7,379 skilled nursing facilities (SNFs), 124 comprehensive outpatient rehabilitation facilities, 5,887 home health agencies (HHAs), and 4,381 independent laboratories. Other participating health care providers included 765 ambulatory surgical centers, 390 hospices, 451 rural health clinics and 1,644 end-stage renal disease (ESRD) facilities or units providing services to Medicare beneficiaries requiring maintenance dialysis or kidney transplants.

### Participating Physicians and Suppliers

About 30 percent of the physicians (159,091) and 18.6 percent of the medical suppliers (14,052) serving Medicare beneficiaries signed participation agreements with HCFA for the 1987 calendar year. Physicians and suppliers may make a voluntary choice each year to participate in Medicare and to accept assignment on all Medicare claims. Participating physicians and suppliers agree to accept Medicare approved amounts as payment in full for their services regardless of the actual charges. Beneficiaries are billed only for applicable deductible and coinsurance amounts.

### Benefit Payments

Medicare benefit payments totaled about $79.75 billion in FY 87, or 7.7 percent more than the benefit outlay for the previous fiscal year. Benefits paid under the hospital insurance program (Part A) amounted to $49.813 billion, while those paid under the supplementary medical insurance (SMI) program (Part B) totaled $29.937 billion. Inpatient hospital care accounted for $46.8 billion, or 94 percent, of Part A spending while 4.9 percent went for home health care, and about one percent for SNF care. The balance was spent on hospice

Table 1.

OVER 32 MILLION PERSONS HAVE SOME MEDICARE COVERAGE:
PROPORTION OF HIGH USE GROUPS RISES

(numbers in thousands)

| Year | Total | Aged | | | Disabled | | |
|---|---|---|---|---|---|---|---|
| | | Total | 85+ Number | 85+ Percent | Total | ESRD Only | All ESRD[1] |
| 1987 | 32,411 | 29,380 | 3,024 | 10.3% | 3,031 | 47 | 131 |
| 1986 | 31,749 | 28,791 | 2,932 | 10.2% | 2,959 | 39 | 120 |
| 1985 | 31,083 | 28,176 | 2,861 | 10.2% | 2,907 | 31 | 103 |
| 1984 | 30,455 | 27,571 | 2,778 | 10.1% | 2,884 | 30 | 98 |
| 1980 | 28,478 | 25,515 | 2,410 | 9.4% | 2,963 | 28 | 67 |
| 1973 | 23,545 | 21,815 | 1,699 | 7.8% | 1,731 | 6 | 10 |
| 1966 | 19,109 | 19,109 | 1,183 | 6.2% | -- | -- | -- |

[1]Sum of aged with ESRD, disabled with ESRD, and those entitled because of ESRD only (2991).

NOTE: Total enrollees residing in U.S., in territories and possessions, and in foreign countries.

Table 2.

MEDICARE TOUCHES MORE AND MORE PEOPLE:
ONE OUT OF EIGHT HAS SOME MEDICARE COVERAGE

| Year | U.S. Resident Population | U.S. Medicare Population | Medicare as Percent of Resident Population |
|---|---|---|---|
| | (in thousands) | | |
| 1987 | 243,400 | 31,738 | 13.0% |
| 1986 | 241,078 | 31,090 | 12.9% |
| 1985 | 238,741 | 30,437 | 12.7% |
| 1984 | 236,447 | 29,824 | 12.6% |
| 1980 | 227,255 | 27,890 | 12.3% |
| 1973 | 211,357 | 23,104 | 10.9% |
| 1966 | 195,576 | 18,824 | 9.6% |

Table 3.

Almost 96% of the U.S. Medicare population is entitled to both HI & SMI

Note: Numbers in thousands

| | All Areas | | | U.S. | | | Possessions & Territories | | | Foreign Countries | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Program Coverage | Total | Aged | Disabled | Total | Aged | Disabled | Total | Aged | Disabled | Total | Aged | Disabled |
| HI &/or SMI* | 32,411 | 29,380 | 3,031 | 31,738 | 28,813 | 2,924 | 418 | 326 | 93 | 255 | 241 | 14 |
| HI | 31,853 | 28,822 | 3,031 | 31,181 | 28,257 | 2,924 | 417 | 324 | 93 | 255 | 241 | 14 |
| SMI | 31,170 | 28,382 | 2,788 | 30,851 | 28,116 | 2,735 | 273 | 224 | 49 | 46 | 42 | 4 |
| HI & SMI | 30,612 | 27,824 | 2,788 | 30,294 | 27,559 | 2,735 | 272 | 223 | 49 | 46 | 42 | 4 |
| HI only | 1,241 | 998 | 243 | 887 | 697 | 189 | 145 | 101 | 43 | 210 | 199 | 10 |
| SMI only | 558 | 558 | a | 557 | 557 | a | 1 | 1 | a | a | a | a |

Percentage Distribution

| | All Areas | | | U.S. | | | Possessions & Territories | | | Foreign Countries | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Program Coverage | Total | Aged | Disabled | Total | Aged | Disabled | Total | Aged | Disabled | Total | Aged | Disabled |
| HI &/or SMI | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| HI | 98.3% | 98.1% | 100.0% | 98.2% | 98.1% | 100.0% | 99.6% | 99.5% | 100.0% | 100.0% | 100.0% | 100.0% |
| SMI | 96.2% | 96.6% | 92.0% | 97.2% | 97.6% | 93.5% | 65.3% | 68.9% | 53.0% | 17.9% | 17.4% | 26.8% |
| HI & SMI | 94.4% | 94.7% | 92.0% | 95.5% | 95.6% | 93.5% | 65.0% | 68.4% | 53.0% | 17.9% | 17.4% | 26.8% |
| HI only | 3.8% | 3.4% | 8.0% | 2.8% | 2.4% | 6.5% | 34.7% | 31.1% | 47.0% | 82.1% | 82.6% | 73.2% |
| SMI only | 1.7% | 1.9% | 0.0% | 1.8% | 1.9% | 0.0% | 0.4% | 0.5% | 0.0% | 0.0% | 0.0% | 0.0% |

* Unduplicated count of U.S. residents enrolled in one or both parts of the Medicare program.
a Less than 500

care. Physician services and independent laboratory costs accounted for 76.1 percent, outpatient services for 19.3 percent, and home health care and prepayment plans for 4.6 percent of Part B spending. The $21.9 billion spent for physician services was 18.2 percent higher than the FY 86 outlay and represented nearly 75 percent of Part B spending for the year. Part A benefit payments to hospices increased 80 percent over FY 86, rising from $35 million to $63 million, and Part B benefit payments to group practice plans rose 40.2 percent over the same period, from $953 million to $1.336 billion.

### Program Funding

Ninety-two percent of the financing for Medicare Part A is derived from employment taxes paid by workers and their employers, and by self-employed individuals. The remainder comes from Federal general revenues and other sources. Part B is financed by three sources: (1) premium payments from enrollees (25 percent); (2) contributions from general revenues 72 percent); and (3) interest on balances in the SMI Trust Fund (3 percent). Enrollees paid a monthly Part B premium of $17.90 in FY 1987.

## ENSURING QUALITY OF CARE

Peer Review Organizations (PROs) under the aegis of HCFA concentrated during the fiscal year on monitoring the quality of care afforded Medicare beneficiaries and ensuring compliance by Medicare providers with the provisions of the prospective payment system (PPS). Major areas scrutinized by the PROs included hospital admissions, readmissions and transfers, accuracy of coding, and day and cost outlier cases. During FY 1987 PROs identified 34,761 physicians and 1,316 hospitals with possible quality-of-care problems, and cited 509 physicians and 74 providers for potential substantial or gross and flagrant violations of Medicare standards. They further found that more than 75,000 discharges failed one or more of HCFA-provided generic quality screens. Additionally, it was reported that 5,992 Medicare patients out of 658,461 whose cases were reviewed by PROs during the fiscal year were discharged prematurely or were readmitted for care that should have been provided during the first admission.

## ENCOURAGING COMPETITION AND CHOICE

HCFA maintained emphasis throughout the year on the importance of providing Medicare beneficiaries with an alternative to traditional fee-for-service health care by expanding the availability of prepayment health plans, such as health maintenance organizations (HMOs) and competitive medical plans (CMPs). By the end of the fiscal year the number of HMOs and CMPs under contract with HCFA had increased from 143 to 157, and the number of beneficiaries enrolled in prepayment plans rose from 772,488 to 958,345 (Table 4).

### International Medical Centers' Contract Terminated

HCFA terminated its contract during FY 1987 with International Medical Centers (IMC), a risk-contracting Medicare HMO serving more than 130,000 Medicare beneficiaries in Florida. IMC was cited for numerous deficiencies by HCFA and, in a subsequent and separate action, was declared insolvent by the State of Florida Department of Insurance and placed in receivership. Humana Medical Plan, Inc., purchased IMC's assets and entered into a contract with HCFA agreeing to serve more than 118,000 Medicare beneficia-

ries previously covered by IMC. In terminating the contract with IMC, HCFA initiated numerous actions to protect the interests of Medicare beneficiaries.

### Medicare Insured Group Demonstration Planned

Work continued in FY 1987 on plans for a demonstration program to expand Medicare risk contracting to employers and unions that provide health benefits to their retirees. Under the Medicare insured groups (MIGs) demonstration, an employer or union would receive a monthly capitation for each Medicare beneficiary enrolled in a managed care plan sponsored by a MIG. The sponsoring employer or union would then assume medical and financial responsibility for providing both Medicare and other health benefits to its retirees. Amalgamated Life Insurance Company (ALICO) submitted the first research and demonstration proposal for participation in the demonstration program.

## IMPROVED OPERATIONAL EFFORTS

### Distribution of Claims

Medicare intermediaries received 67.2 million claims in FY 1987, a 5 percent increase over FY 1986; Medicare carriers received 334.1 million claims, for an 11 percent increase. An improved system for preparing and mailing notices of claims payments to Medicare beneficiaries was introduced during the fiscal year with the result that they now receive notice of a Medicare payment within two weeks, or 5.5 times faster than under the old system.

### Medicare Secondary Payer Provisions

The Medicare Secondary Payer (MSP) provisions, which cost $56 million to administer, produced more than $1.4 billion in savings in FY 1987, for a cost-benefit ratio of 1:25. The provisions determine when Medicare is a secondary payer and another insurer is the primary payer of a Medicare beneficiary's claims for covered medical services and supplies. The Omnibus Budget Reconciliation Act of 1986 (OBRA 86) made Medicare a secondary payer for items and services provided after December 31, 1986, to disabled Medicare beneficiaries who qualify as "active individuals" and are enrolled in large group health plans (LGHPs). An "active individual" is defined in the law as an employee, the employer, an individual associated with the employer in a business relationship, and family members of any of the preceding individuals.

### Payments Limited to Hospitals for Certain Surgery

HCFA implemented Section 9343 of OBRA 86 which enacted Section 1833(i)(3) of the Social Security Act to place a payment limitation on hospitals for certain surgical procedures that also are approved for ambulatory surgery centers (ASCs). Payment for these procedures must be based, in part, on what Medicare would have paid for the same surgery had it been performed in an approved ASC.

### Other Reimbursement Policy Issues

Both Part A and Part B Medicare contractors were required as of the beginning of FY 1987 to pay at least 95 percent of all "clean" claims within 30 days, 95 percent of all claims

Table 4.

MEDICARE CONTRACTS WITH HMOs/CMPs

| Type of Contract | Contracts 10/1/86 | Contracts 9/30/87 | Enrollees 10/1/86 | Enrollees 9/30/87 | Payment FY 1987 |
|---|---|---|---|---|---|
| TEFRA Risk | 143 | 157[1] | 772,488 | 958,345 | $2,184.3 |
| Cost | 45 | 42[2] | 133,596 | 131,511 | 101.8 |
| Other | | | | | |
| Old Risk | 4 | 4 | 48,404 | 52,284 | 91.4 |
| Demos | 8 | 7 | 28,047 | 29,494 | 81.2 |
| HCPP | 36 | 34[3] | 615,934 | 620,213 | 422.0 |
| Total | 236 | 244 | 1,598,469 | 1,791,847 | $2,880.7 |

Note: Dollars in millions.

[1] Includes 11 contracts which have been signed, but for which no payment has been made.
[2] Includes 14 cost plans which have signed TEFRA risk contracts but still have enrollees being paid for under the cost method.
[3] Includes enrollment from 10 health care prepayment plans (HCPPs) that have signed risk contracts.

within 60 days and 99 percent within 90 days. By the end of the fiscal year nearly all contractors had met the claims processing timeliness (CPT) deadlines.

### Beneficiary Services by Medicare Carriers and Intermediaries

During FY 1987, Medicare carriers handled 16,203,604 beneficiary inquiries, while Medicare intermediaries handled 1,571,085. In addition, carriers handled 6,583,087 provider inquiries.

### Electronic Claims

More than 46 million Medicare claims processed by intermediaries and about 103 million processed by carriers were transmitted electronically during the fiscal year. This exceeded the year's goal for increasing HCFA's reliance on the more cost-effective electronic transactions.

### Replacement Contractors

Following a three-year performance rating, HCFA identified Blue Cross and Blue Shield of the National Capital Area as a Medicare contractor for possible replacement. The company subsequently withdrew as a Medicare Part A contractor and its workload was reassigned to Blue Cross and Blue Shield of Maryland, Inc., and Blue Cross and Blue Shield of Virginia.

### Contractor Performance Evaluation Program

The Contractor Performance Evaluation Program (CPEP) contains performance standards designed to prevent the inappropriate expenditure of Medicare funds. Thirty-six discrete payment safeguard standards were applied during the year in evaluating intermediary performance in the areas of bill processing, medical review, and provider reimbursement, while 25 were used to measure intermediary performance in the areas of claims processing and medical review. The percentage of contractors meeting or exceeding the standards increased from 91.6 in FY 1986 to 96.2 in FY 1987.

### Operational Reviews

Operational reviews instituted during the year monitored physician reimbursement levels associated with cataract surgery, permanent pacemaker implantations, and transurethral resection prostatectomies (TURPs). The appropriateness and financial impact of the laboratory fee schedules were also the subjects of reviews as were the decisions of some fiscal intermediaries in denying home health agency claims for patients discharged from hospitals.

### Carrier Medical Review

Ensuring that Medicare payment is made only for reasonable and necessary physician services is the responsibility of the Medicare carriers. Carriers execute this responsibility through a blend of prepayment reviews of utilization patterns of physician and supplier services. The carrier determination is based on national coverage policy in association with local policy developed by the carrier medical staff. This activity has been cost-effective, with FY 1987 program savings of about $8 for each administrative dollar expended.

### Development of Automated Systems

HCFA operates an automated system that gathers information on the actual amounts and causes of provider overpayments and associated interest, the recoupments, and the time associated with recovery. The average quarterly balances of provider overpayments decreased during the fiscal year by $66 million, a 24 percent reduction over the previous fiscal year's amount.

### Medicare Heart Transplant Centers

During the fiscal year HCFA designated eight Medicare heart transplant centers: the Medical College of Virginia, Richmond, Virginia; Stanford University Medical Center, Stanford, California; University of Minnesota Hospital and Clinic, Minneapolis, Minnesota; University of Arizona Health Sciences Center, Tucson, Arizona; Johns Hopkins Hospital, Baltimore, Maryland; Methodist Hospital/Baylor College of Medicine, Houston, Texas; Foster G. McGaw Hospital/Loyola University Medical Center, Maywood, Illinois, and Methodist Hospital of Indiana, Indianapolis, Indiana. The designations were based on the recommendations of outside consultants and made effective retroactively to October 17, 1986.

### Rate Increase

OBRA 86 provided for an increase of 1.15 percent in the standardized amounts and the hospital-specific amounts under the prospective payment system (PPS) and the rate-of-increase limits applicable to hospitals and units excluded from PPS. The increase was retroactively adjusted for all of FY 1987.

## RESEARCH, DEMONSTRATIONS, AND EVALUATIONS

Research, demonstration, and evaluation projects were conducted during the fiscal year in the areas of hospital payment, physician payment, State programs for long-term care, alternative payment systems, program analysis and evaluation, quality and coverage, and beneficiary awareness and preventive care. Besides funding various intramural projects, HCFA spent nearly $28 million in FY 1987 for research and demonstration (R&D) grants and contracts in seven program areas.

## PROMOTING INTERNAL IMPROVEMENTS

HCFA management accomplishments during the year included implementation of the delegation of leasing authority (DOLA) for all agency buildings, overhaul of the agency's internal control program, introduction of a two-year management training program for high-potential employees, and an intensified effort to attract highly qualified job applicants. FY 1987 departmental procurement preference and competition goals were also exceeded in the awarding of more than $60 million in contracts.

## VALIDATION SURVEYS OF HOSPITALS

The purpose of the Medicare validation program is to determine the effectiveness of the Joint Commission on Accreditation of Healthcare Organizations (JCAH) accreditation process in providing reasonable assurance that hospitals comply with the intent of the Medicare conditions of participation. Each year a statistical sample of the approximately 5,100 JCAHO-accredited hospitals is selected for validation surveys. Under contract with the Secretary of Health and Human Services (HHS), State agencies (SAs) conducted 61 validation surveys during the fiscal year.

HCFA's validation analysis was conducted in two areas: Life Safety Code (LSC) and general health and safety requirements. The LSC of the National Fire Protection Association is a consensus standard adopted by reference in Federal regulations that provides a reasonable level of safety from fire and emergencies. During FY 1987, 75 percent (46 of 61) of validated hospitals were in compliance with general health and safety conditions.

In addition to the surveys conducted at selected hospitals, other accredited hospitals are subject to an SA survey when there is an allegation that significant deficiencies threaten the health and safety of their patients. For this report period, 606 hospitals received allegation investigations, and 9 percent (52 of 606) were found out of compliance with one or more conditions.

## MEDICARE SUPPLEMENT INSURANCE

HCFA continued to monitor the compliance of applicable State statutes and regulations with the minimum standards contained in the Federal law on Medicare supplement or so-called "Medigap" insurance. These standards, developed by the National Association of Insurance Commissioners (NAIC) and incorporated into the Federal statute, are intended to provide minimum benefits and protections for individuals who wish to purchase private health insurance to supplement their Medicare coverage.

In addition, the Federal law provides criminal penalties for certain fraudulent or abusive marketing practices. HCFA screens complaints received from consumer organizations, individuals, and other Government agencies and refers actionable cases to HHS' Office of the Inspector General (OIG) or to the appropriate State insurance department, or to both, for investigation and prosecution.

HCFA was informed of 20 possible violations of the penalty provisions in FY 1986 and 9 in FY 1987. All of these cases were closed out due to either a lack of evidence or referral to specific State insurance departments for investigation of possible violations of State laws.

CHAPTER I

# THE MEDICARE POPULATION AND BENEFITS

## INTRODUCTION

Medicare enrollment increased 2.1 percent during FY 1987, from 31.75 to 32.41 million, and benefit outlays rose 7.7 percent, from $74.036 billion to $79.75 billion.

## MEDICARE BENEFICIARIES

Approximately 661,000 individuals were added to the Medicare rolls during the year. Some 589,000 of the new enrollees were 65 years of age or older, bringing to 29.38 million the number of elderly beneficiaries, and 72,000 were younger disabled persons, increasing the number of disabled beneficiaries to 3.03 million. Included among the disabled were 47,000 with end-stage renal disease who must meet eligibility requirements different than those for other disabled beneficiaries.

Of the 32.41 million beneficiaries, 31.74 million were residents of one of the 50 States or the District of Columbia, 407,000 resided in Puerto Rico, 6,700 in the Virgin Islands, 3,400 in Guam, and 1,400 in American Samoa, the Northern Mariana Islands and other outlying areas. Another 255,000 resided in foreign countries. Nearly 96 percent of the Medicare population in the 50 states and the District of Columbia, 65 percent of the beneficiaries in U.S. commonwealths and territories, and 18 percent of the beneficiaries in foreign coun tries, were enrolled in both Medicare Part A and Part B.

Women accounted for 57.8 percent of the total Medicare population, 60 percent of the eldest beneficiaries and 36.6 percent of the disabled enrollees. The percentage of disabled men, while down slighly in FY 1987 to 63.4, has remained relatively constant since FY 1980 as has the percentage of aged who are men.

Minorities represent a growing proportion of the Medicare population (Table 5). In FY 1987, 3.364 million Medicare enrollees were other than white. This represented 10.7 percent of the Medicare population, a rise of 4.3 percent over FY 1986 and an increase of 22.6 percent over FY 1980 when 9.9 percent of beneficiaries were non-white. While non-whites made up only 9.8 percent of aged beneficiaries, 19.6 percent of the disabled beneficiaries were other than white, an increase of nearly 1 percent over the figure for the previous fiscal year.

A significant demographic trend that has and will continue to affect Medicare is the increasing median age of beneficiaries. In FY 1973, 1.699 million beneficiaries, or 7.8 percent of the elderly population, were 85 and older. In FY 1987, 3.024 million, or 10.3 percent of the aged population, were in the 85-and-over category. The aging of the Medicare population is an important economic factor as older beneficiaries generally require greater and more intense health care services than do younger beneficiaries.

Table 5. WOMEN AND MINORITIES:
A GROWING PROPORTION OF THE MEDICARE POPULATION

| YEAR | SEX | | | | RACE[1] | | | |
|---|---|---|---|---|---|---|---|---|
| | Number | | Percent | | Number | | Percent | |
| | MALE | FEMALE | MALE | FEMALE | WHITE | OTHER | WHITE | OTHER |
| | (numbers in thousands) | | | | | | | |
| | TOTAL | | | | | | | |
| 1987 | 13,684 | 18,727 | 42.2% | 57.8% | 28,081 | 3,364 | 89.3% | 10.7% |
| 1986 | 13,406 | 18,344 | 42.2% | 57.8% | 27,592 | 3,226 | 89.5% | 10.5% |
| 1985 | 13,128 | 17,955 | 42.2% | 57.8% | 27,081 | 3,098 | 89.7% | 10.3% |
| 1984 | 12,874 | 17,580 | 42.3% | 57.7% | 26,578 | 3,000 | 89.9% | 10.1% |
| 1980 | 12,139 | 16,340 | 42.6% | 57.4% | 24,956 | 2,744 | 90.1% | 9.9% |
| | AGED | | | | | | | |
| 1987 | 11,762 | 17,619 | 40.0% | 60.0% | 25,691 | 2,780 | 90.2% | 9.8% |
| 1986 | 11,525 | 17,266 | 40.0% | 60.0% | 25,237 | 2,678 | 90.4% | 9.6% |
| 1985 | 11,282 | 16,894 | 40.0% | 60.0% | 24,745 | 2,585 | 90.5% | 9.5% |
| 1984 | 11,044 | 16,526 | 40.1% | 59.9% | 24,252 | 2,498 | 90.7% | 9.3% |
| 1980 | 10,268 | 15,247 | 40.2% | 59.8% | 22,534 | 2,257 | 90.9% | 9.1% |
| | DISABLED | | | | | | | |
| 1987 | 1,922 | 1,108 | 63.4% | 36.6% | 2,390 | 584 | 80.4% | 19.6% |
| 1986 | 1,881 | 1,078 | 63.6% | 36.4% | 2,355 | 548 | 81.1% | 18.9% |
| 1985 | 1,846 | 1,061 | 63.5% | 36.5% | 2,336 | 513 | 82.0% | 18.0% |
| 1984 | 1,830 | 1,054 | 63.5% | 36.5% | 2,326 | 502 | 82.2% | 17.8% |
| 1980 | 1,871 | 1,093 | 63.1% | 36.9% | 2,422 | 487 | 83.3% | 16.7% |

[1] Excludes race unknown.

## BENEFIT EXPENDITURES

Medicare benefit payments for the fiscal year totaled $79.75 billion, or about $5.7 billion more than for FY 1986 (Table 6). About 12 percent of the increase was attributable to higher inpatient hospital costs, 59 percent to higher physician charges recognized by Medicare, and 15 percent to higher outpatient hospital costs. Higher charges assessed by group practice plans, home health, and independent laboratories accounted for the balance of the increase. Medicare benefit payments for FY 1987 were broken down as follows:

* Hospital Insurance (Part A)—$49.8 billion
* Supplementary Medical Insurance (Part B)—$29.9 billion

## HOSPITAL INSURANCE

Part A spending, which was 1.9 percent higher than in FY 1986, was divided among its components as follows:

| Benefit | FY 1986 | FY 1987 | % Change |
|---|---|---|---|
| | (Dollars in Millions) | | |
| Inpatient Hospital | $46,042 | $46,842 | 1.7 |
| Skilled Nursing Facility | 568 | 627 | 7.2 |
| Home Health | 2,204 | 2,281 | 3.5 |
| Hospice | 35 | 63 | 80.0 |

While spending for home health and skilled nursing facilities grew at a faster rate than in FY 1986 spending for inpatient hospitals and hospice care slowed from the previous fiscal year.

## SUPPLEMENTARY MEDICAL INSURANCE

Part B, which, at $29.9 billion, was 18.9 percent higher than in FY 1986, was broken down as follows:

| Benefit | FY 1986 | FY 1987 | % Change |
|---|---|---|---|
| | (Dollars in Millions) | | |
| Physicians | $18,553 | $21,926 | 18.2 |
| Outpatient Services | 4,921 | 5,780 | 17.5 |
| Group Practice | 953 | 1,336 | 40.2 |
| Independent Laboratory | 694 | 847 | 22.0 |
| Home Health | 48 | 48 | 0.0 |

As was the case in the last fiscal year, the largest increases in terms of expenditures were for physician and outpatient services. The rate of growth in the cost of physician services in FY 1987 was nearly double the rate for FY 1986, while the rate of growth in expenditures for outpatient services slowed.

Table 6. MEDICARE BENEFIT PAYMENTS SHIFT TO PART B SERVICES

| Fiscal Year | Total Medicare | Total Hospital Insurance | Inpatient Hospital | Inpatient SNF | HHA | Hospice | Total Supplementary Medical Insurance | Physician and Independent Lab | Outpatient | HHA | GPPP |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Benefit Payments(in millions) | | | | | | |
| 1987 | $79,750 | $49,813 | 46,842 | $627 | $2,281 | $63 | $29,937 | $22,773 | $5,780 | $48 | $1,336 |
| 1986 | 74,036 | 48,867 | 46,043 | 568 | 2,204 | 35 | 25,169 | 19,247 | 4,921 | 48 | 953 |
| 1985 | 69,518 | 47,710 | 45,017 | 567 | 2,111 | 15 | 21,808 | 17,281 | 3,903 | 53 | 571 |
| 1984 | 60,934 | 41,461 | 39,080 | 535 | 1,844 | 2 | 19,473 | 15,449 | 3,534 | 25 | 465 |
| 1983 | 55,588 | 38,101 | 36,076 | 515 | 1,510 | -- | 17,487 | 13,708 | 3,346 | 22 | 411 |
| | | | | | Percent Distribution | | | | | | |
| 1987 | 100.0% | 61.8% | 57.9% | 0.7% | 3.0% | 0.1 % | 37.5% | 28.6% | 7.2% | 0.1 % | 1.7% |
| 1986 | 100.0% | 65.1% | 61.3% | 0.8% | 3.0% | <0.05% | 33.5% | 25.6% | 6.6% | 0.1 % | 1.3% |
| 1985 | 100.0% | 67.7% | 63.9% | 0.8% | 3.0% | <0.05% | 30.9% | 24.5% | 5.5% | 0.1 % | 0.8% |
| 1984 | 100.0% | 67.1% | 63.2% | 0.9% | 3.0% | <0.05% | 31.5% | 25.0% | 5.7% | <0.05% | 0.8% |
| 1983 | 100.0% | 67.5% | 63.9% | 0.9% | 2.7% | -- | 31.0% | 24.3% | 5.9% | <0.05% | 0.7% |
| | | | | | Benefit Payments Per Enrollee | | | | | | |
| 1987 | $2,488 | $1,564 | $1,466 | $19 | $77 | $2.0 | $989 | $731 | $185 | $2 | $43 |
| 1986 | 2,365 | 1,565 | 1,475 | 18 | 71 | 1.1 | 857 | 629 | 161 | 2 | 31 |
| 1985 | 2,266 | 1,560 | 1,472 | 19 | 69 | 0.5 | 758 | 576 | 130 | 2 | 19 |
| 1984 | 2,030 | 1,382 | 1,303 | 18 | 62 | 0.1 | 693 | 525 | 120 | 1 | 16 |
| 1983 | 1,879 | 1,288 | 1,219 | 17 | 51 | -- | 632 | 473 | 115 | 1 | 14 |
| | | | | | Percent Change in Benefit Payments from Prior Year | | | | | | |
| 1987 | 7.7% | 1.9% | 1.7% | 7.2% | 3.5% | 80.0% | 18.9% | 18.3% | 17.5% | 0% | 40.2% |
| 1986 | 6.6% | 2.4% | 2.3% | 2.5% | 3.9% | 133.3% | 15.4% | 11.4% | 26.1% | -9.4% | 66.9% |
| 1985 | 13.9% | 15.1% | 15.2% | 6.5% | 15.1% | 750.0% | 12.0% | 11.9% | 10.4% | 112.0% | 22.8% |
| 1984 | 9.6% | 8.8% | 8.3% | 5.1% | 21.6% | -- | 11.4% | 12.7% | 5.6% | 13.6% | 13.1% |

### Hospital Services

Of all purchases, hospital care accounted for the largest portion of Medicare spending in FY 1987. Nearly 59 percent of Medicare's total benefit expenditures and 94 percent of Part A outlays went for inpatient hospitalization. This was so even though there was a reduction in the number of inpatient hospital admissions, discharges and days of care. Admissions were down 1.8 percent, discharges 3.9 percent and days of care 2 percent from the FY 86 levels. Under Part A, beneficiaries are eligible for 90 days of inpatient hospital care in a benefit period. In addition, they are eligible for 60 "lifetime reserve days."

### Skilled Nursing Facility Services

Medicare paid $627 million for skilled nursing facility (SNF) services in FY 87, or about 7.2 percent more than in the last fiscal year. The cost of SNF services accounted for about 7.9 percent of Part A outlays during the year. Medicare beneficiaries are entitled to 100 days of covered care during a benefit period in a skilled nursing facility after an inpatient hospitalization of at least three consecutive days, provided certain conditions are met.

### Home Health Services

The $2.3 billion spent on home health services during the fiscal year was 3.5 percent higher than in FY 1986 and accounted for about 4.6 percent of Part A spending. Part A covers home health visits with no prior hospitalization requirement. The care needed must include part-time or intermittent skilled nursing care, physical therapy or speech therapy, and the patient must be confined to home.

### Hospice Services

The greatest percentage increase in any single category of Medicare spending during FY 1987 was for hospice care, which increased 80 percent, from $35 million in FY 86 to $63 million. The rise was primarily due to the growing popularity of hospice care, which accounted for $2 million in Medicare spending when it was introduced as a benefit in 1984. Part A of Medicare pays for hospice care when a physician certifies that a patient is terminally ill; the patient chooses hospice care instead of standard Medicare benefits for the terminal illness; and care is provided by a hospice program approved by Medicare.

### Physician Services and Medical Supplies

Expenditures for physician services totaled $21.9 billion for the fiscal year. This was 18.2 percent higher than the FY 1986 outlay and represented nearly 75 percent of Part B spending for the year. Part B pays 80 percent of Medicare-approved charges for medical services after the beneficiary pays the first $75 in approved charges each calendar year.

### Outpatient Services

Medicare spending for outpatient services rose 17.5 percent over FY 1986, increasing from $4.921 billion to $5.78 billion. Although relatively high, the percentage increase was lower than the 26.1 percent increase registered in FY 1986. Outpatient services provided by hospitals are covered under Part B.

### Group Practice Plans

Part B expenditures for group practice plans increased from $953 million in FY 1986 to $1.336 billion in FY 1987, or 40.2 percent. This was the highest percentage increase of any component of Part B and reflects the increased number of Medicare beneficiaries enrolled in prepayment plans, such as health maintenance organizations (HMOs) and competitive medical plans (CMPs).

### Independent Laboratories

Spending for independent laboratory services under Part B increased 22 percent, from $694 million in FY 1986 to $847 million.

### Home Health Care

Because most home health care is covered by Medicare Part A, only a small amount of such care is provided under Part B. Part B spending for home health care totaled $48 million in FY 1987, or the same amount as for the previous fiscal year.

## PROVIDERS

### Hospitals

The number of participating hospitals increased in FY 1987 from 6,720 to 6,734 (Table 7). The number of short-stay hospitals slipped from 5,994 to 5,895 and other long-stay hospitals increased from 217 to 278. At the same time, psychiatric hospitals increased from 509 to 561.

Short-stay hospital admissions declined an estimated 1.9 percent for the fiscal year to 10.4 million following a fall-off of about 2.8 percent in FY 1986 (Table 8). Reductions also were registered in the average number of discharges and days of care per 1,000 Medicare enrollees (Table 9). There were 330 discharges per 1,000 beneficiaries in FY 1987 compared with 343 discharges per 1,000 beneficiaries for the previous 12-month period. Similarly, the 2,888 days of care per 1,000 enrollees in FY 1987 were 2.0 percent fewer than in FY 1986. The average length of a hospital stay leveled off at about 8.7 days during the fiscal year (Table 10).

### Skilled Nursing Facilities

The number of SNFs rose from 6,897 to 7,379 in FY 1987, and the number of SNF beds increased by about 1,000 to 450,000 (Table 11).

### Home Health Agencies

After increasing by 300 in FY 1986, the number of home health agencies decreased by 91 in FY 1987, from 5,978 to 5,887.

### Other Providers

Other providers participating in Medicare during the fiscal year included 4,381 independent laboratories, 1,644 end-stage renal disease (ESRD) facilities, 124 comprehensive outpatient rehabilitation facilities, 765 ambulatory surgical centers and 390 hospices.

## PROGRAM FUNDING

Under the Social Security Act, the Federal Hospital Insurance (Part A) and the Federal Supplementary Medical Insurance (Part B) Trust funds are administered by two boards of trustees, each with the same five members. Three members serve in an ex officio capacity: The Secretary of Treasury, who by law serves as managing trustee of both funds, the Secretary of Labor, and the Secretary of Health and Human Services. Two public members are nominated by the President for four-year terms subject to confirmation by the Senate. The Administrator of HCFA serves as secretary of both boards.

The primary source of Part A financing (92 percent) is derived from payroll taxes paid by workers and their employers and by self-employed individuals. The remaining 8 percent comes from Federal general revenues for certain insured individuals who attained age 65 before 1975, premium payments for voluntarily enrolled individuals, transfers from the Railroad Retirement Board, military service credits, and interest on accumulated funds.

Part B is financed by three sources: (1) premium payments from enrollees, (2) contributions from general revenues, and (3) interest on trust fund reserves. The Part B premium under the Tax Equity and Fiscal Responsibility Act and the Deficit Reduction Act is set at 25 percent of program costs. In FY 1987 beneficiary premiums covered 23 percent, and government contributions 73 percent, of the cost of Part B. Interest on trust fund reserves covered the other four percent.

More detailed information about the status of the trust funds, showing income, disbursement and future projections, is contained in the annual reports to the Congress by the trustees of the respective funds.

Table 7.

NUMBER OF BEDS DECLINE IN 1987

| | 1975 | 1980 | 1984 | 1985 | 1986 | 1987 |
|---|---|---|---|---|---|---|
| Total Hospitals | 6,773 | 6,777 | 6,675 | 6,707 | 6,720 | 6,734 |
| Beds (thousands) | 1,140 | 1,150 | 1,144 | 1,144 | 1,146 | 1,136 |
| Beds per 1,000 Enrollees | 51.7 | 46.7 | 42.6 | 42.5 | 41.7 | 40.6 |
| Short-Stay | 6,107 | 6,104 | 6,038 | 6,034 | 5,994 | 5,895 |
| Beds (thousands) | 902 | 991 | 1,023 | 1,027 | 1,026 | 1,008 |
| Beds per 1,000 Enrollees | 40.9 | 40.2 | 38.1 | 38.2 | 36.6 | 36.0 |
| Psychiatric | 385 | 408 | 433 | 474 | 509 | 561 |
| Beds (thousands) | 199 | 131 | 97 | 95 | 97 | 96 |
| Beds per 1,000 Enrollees | 9.0 | 5.3 | 3.6 | 3.5 | 3.5 | 3.4 |
| Other Long-Stay[1] | 281 | 265 | 204 | 199 | 217 | 278 |
| Beds (thousands) | 40 | 28 | 23 | 22 | 23 | 33 |
| Beds per 1,000 Enrollees | 1.8 | 1.1 | 0.9 | 0.8 | 0.8 | 1.2 |

(As of July 1)

[1]Beginning October 1, 1983, a number of short-stay pediatric, rehabilitation, and alcohol/drug hospitals were re-assigned non-short-stay provider numbers and are included in this category for 1984, 1985, and 1986.

Table 8. INPATIENT HOSPITAL ADMISSIONS TREND DOWNWARD SINCE FY 1983

| Fiscal Year | All Inpatient Hospital Admissions and Transfers | | Short-Stay Hospital and Excluded Unit Admissions | | Short-Stay Hospital Admissions Only | |
|---|---|---|---|---|---|---|
| | Number | Percent Change | Number | Percent Change | Number | Percent Change |
| | (numbers in thousands) | | | | | |
| 1982 | 11,369 | --- | 11,218 | --- | 11,218 | --- |
| 1983 | 11,841 | 4.2 | 11,702 | 4.3 | 11,702 | 4.3 |
| 1984 | 11,766 | -0.6 | 11,618 | -0.7 | 11,534 | -1.4 |
| 1985(est.) | 11,200 | -4.8 | 11,000 | -5.3 | 10,900 | -5.5 |
| 1986(est.) | 11,000 | -1.8 | 10,800 | -1.8 | 10,600 | -2.8 |
| 1987(est.) | 10,800 | -1.8 | 10,600 | -1.9 | 10,400 | -1.9 |

Table 9. DECLINE IN ADMISSIONS AND LENGTH OF STAY RESULTS IN 26% DECREASE IN DAYS OF CARE UTILIZATION RATE SINCE 1982

| Year | Rate per 1,000 Enrolled | | | |
|---|---|---|---|---|
| | Discharges | | Days of Care | |
| | Rate | Percent Change | Rate | Percent Change |
| 1982 | 382 | --- | 3,933 | --- |
| 1983 | 392 | 2.6% | 3,918 | -0.4% |
| 1984 | 383 | -2.3% | 3,534 | -10.7% |
| 1985(est.) | 356 | -7.6% | 3,106 | -13.8% |
| 1986(est.) | 343 | -3.8% | 2,947 | -5.4% |
| 1987(est.) | 330 | -3.9% | 2,888 | -2.0% |

Table 10. PPS EFFECT ON LENGTH OF STAY LEVELS OFF: LENGTH OF STAY IN NON-WAIVER STATES UP SLIGHTLY IN 1987

| | | | | | FY 1987 | |
|---|---|---|---|---|---|---|
| | FY 1983 | FY 1984 | FY 1985 | FY 1986 | Prior Grouping | Current Grouping |
| All Areas | 10.0 | 9.1 | 8.6 | 8.6 | 8.7[1] | 8.7[2] |
| Non-waiver States | 9.5 | 8.6 | 8.0 | 8.5 | 8.2[1] | 8.6[2] |
| PPS only | --- | 7.7 | 7.9 | 8.2 | 8.0[3] | 8.3[4] |
| Waiver States | 13.2 | 12.7 | 12.1 | 10.9 | 11.5[3] | 11.0[4] |
| Outlying Areas | 9.1 | 8.7 | 8.4 | 8.0 | 7.7 | 7.7 |

[1] Based on grouping of original 46 non-waiver States and D.C.
[2] Includes utilization for MA & NY with original non-waiver States.
[3] Based on grouping of original 4 waiver States (MD, MA, NJ, NY).
[4] Based on grouping of current waiver States (MD & NJ).

Table 11.

STRONG GROWTH IN MOST PROVIDERS OF ALTERNATIVE CARE

| | 1975 | 1980 | 1984 | 1985 | 1986 | 1987 |
|---|---|---|---|---|---|---|
| Skilled Nursing Facilities | 5,295 | 5,052 | 5,952 | 6,451 | 6,897 | 7,379[1] |
| Beds (thousands) | 287 | 436 | 530 | N/A | 449 | 450 |
| Home Health Agencies | 2,242 | 2,924 | 4,684 | 5,679 | 5,978 | 5,887 |
| Independent Laboratories | 3,048 | 3,447 | 3,801 | 3,980 | 4,138 | 4,381 |
| ESRD Facilities | -- | 999 | 1,334 | 1,394 | 1,449 | 1,644 |
| Outpatient Physical Therapy | 117 | 419 | 791 | 854 | 907 | 977 |
| Portable X-Ray | 132 | 216 | 269 | 308 | 347 | 374 |
| Rural Health Clinics | -- | 391 | 420 | 428 | 432 | 451 |
| Comprehensive Outpatient Rehabilitation Facilities | -- | -- | 48 | 72 | 96 | 124 |
| Ambulatory Surgical Centers | -- | -- | 155 | 336 | 574 | 765 |
| Hospice | -- | -- | 108 | 164 | 268 | 390 |

[1]SNF facility and bed counts are as of January 1; all other counts are as of July 1.
N/A: Not Available
--: Not Applicable

CHAPTER II

# ENSURING QUALITY OF CARE

## INTRODUCTION

One of the priorities of HCFA in FY 1987 was to develop, demonstrate, and evaluate methods for measuring the quality of care afforded Medicare patients by certified providers. The intent was to promote and ensure effective and efficient delivery of all necessary medical services to beneficiaries. As in past years, Peer Review Organizations (PROs) were integral to the quality-assurance effort.

## PEER REVIEW ORGANIZATIONS

PROs are charged by law to assure that services rendered to Medicare beneficiaries are medically necessary, are provided in the most appropriate setting (e.g., acute care hospital versus skilled nursing facility or a lesser level of care), and meet professionally recognized standards of quality. The PRO program was created by the Peer Review Improvement Act of 1982, Title I, Subtitle C of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Public Law 97-248.

PRO reviewers (usually nurses) use criteria for review which are developed by local physicians to approve payment for cases which clearly meet acceptable standards and refer questionable cases to PRO physician-reviewers. If, after review, the PRO physician-reviewer determines there is a quality problem, the PRO will initiate corrective action. If the PRO physician-reviewer determines the care was not medically necessary or that it should have been provided in another setting, the PRO will issue a payment denial. Only a PRO physician-reviewer may deny a case and denials may be made only after the attending physician has been given an opportunity to discuss the case with a PRO physician.

### Quality Review Process

In the second PRO contract cycle (1986-1988) greater emphasis was placed on the quality review process. This resulted in a more structured approach, thus ensuring commitment of a higher percentage of PRO resources to quality-of-care reviews. In stressing quality review, the following actions were taken:

* "Generic screens" were provided as a tool to assist in identifying potential quality problems and were required to be applied to each case undergoing retrospective review.

* Each case selected by the PRO for retrospective review was required to be examined for the appropriateness of the discharge.

* The scope of the PRO objectives were broadened to address quality issues better by focusing on problems identified through generic screen review and HCFA-identified adverse outcomes such as mortality or premature discharge.

**New Areas of Review**

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA 85) authorized PROs to review services provided by HMOs and CMPs with Medicare risk contracts under Section 1876 of the Social Security Act. OBRA 86 extended authority for PRO review to inpatient and outpatient services for Section 1876 contracts. This included authority to determine whether appropriate services were provided and, if so, whether they were accessible, properly utilized, of adequate quality and provided in the appropriate setting. The review for risk-based HMO/CMP services was effective for services rendered on and after April 1, 1987, and was implemented beginning June 1987.

Beginning in August 1987, PROs also were required under OBRA 86 to conduct an appropriate review of all written complaints from beneficiaries about the quality of professional medical services received in HHAs, SNFs, and hospitals. PROs are required to notify the beneficiary of the final disposition of the complaint.

Another provision of OBRA 86 requires PROs to review a sample of cases in which beneficiaries are readmitted to hospitals in less than 31 days of a previous discharge. It is intended to help determine whether patients were prematurely discharged from the first admission. PROs also review, on a sample basis, SNF, HHA, and hospital outpatient care provided between the two hospital admissions. Review in this area was implemented in Pennsylvania and Massachusetts in FY 1987 and is to be introduced in all of the PRO contracts by April 1, 1989.

In addition to expanding PRO reviews beyond the inpatient hospital setting, legislative provisions in FY 1987 strengthened PROs' ability to impact on the delivery of quality care to Medicare beneficiaries. The provisions included:

* The authority to deny Medicare payment for care which was of a substadard quality. (This provision is being implemented through the regulatory process).

* A requirement that each PRO allocate a reasonable proportion of its activities to quality review and that a reasonable allocation is made across all settings.

* Development of pilot studies to assess the effectiveness of clinical interventions by analyzing certain key data elements at the time of the patient's admission, at various stages during the stay and at discharge. The analysis, based on outcomes and treatments rendered, will be used by medical specialists to develop objective standards for physician review of the quality of care.

* Performance of small area analysis. (The data analysis of the patterns of variation in utilization and outcomes of care in 12 States is in progress. A contractor is working with the PROs in the selected states to develop intensified feedback and intervention programs for practitioners in those states based on findings from the data analysis.)

**Findings During FY 1987**

From October 1986 to September 1987, the following potential quality-of-care problems were identified by PROs:

* Physicians identified with possible quality-of-care problems totaled 34,761.

* Hospitals identified with possible quality-of-care problems totaled 1,316.

* Discharges failing one or more HCFA-provided generic quality screens to taled 75,094.

* Physicians (509) and providers (74) with potential substantial or gross and flagrant violations totaled 583.

* Premature discharge of patient and/or readmission of a patient for care that should have been provided during the first admission totaled 5,992 out of 658,461 cases reviewed.

* Inappropriate transfers from a PPS unit to a PPS-exempt unit in the same hospital or a PPS-exempt unit to a PPS unit in the same hospital totaled 355.

## REPORT ON THE LONG-TERM CARE SURVEY PROCESS

Oversight of the care provided to Medicare and Medicaid beneficiaries residing in SNFs and intermediate care facilities (ICFs) is the responsibility of HCFA. This oversight is provided through the conduct of a survey at least once a year of each SNF and ICF participating in either the Medicare or Medicaid program, or both.

Section 1864 of the Social Security Act (the Act) requires the Secretary to enter into agreements with States to survey nursing homes to determine whether they are in compliance with Medicare participation requirements as set forth in Section 1861(j) of the Act. Section 1902(a)(33)(B) of the Act requires a State's Medicaid agency to contract with the State survey agency used by Medicare (if they are responsible for licensing health facilities), to determine whether nursing facilities meet the requirements for participation in the Medicaid program. SNF requirements are in section 1902(a)(28) and ICF requirements are in section 1905(c) and (d) of the Act.

The survey requirements and procedures for Medicare participating facilities are described in 42 CFR Subchapter B, Part 405, while Subchapter C, Part 442 provides that information for Medicaid participating facilities. Over the last several years HCFA, with the advice and assistance of many professional and consumer groups, the long term care industry, and other interested parties, has developed a new long-term care survey process. It is oriented toward evaluating actual resident care rather than focused on the administrative and structural abilities of a facility which indicated its capacity to deliver care.

HCFA continues to refine the long-term care survey process and the instructional material and personnel training integral to its proper implementation. Related activities under taken during the fiscal year included:

* Publication on July 1, 1987, of a notice of proposed rulemaking that provideda detailed description of the new long-term care survey process.

* Publication on July 1, 1987, of an appendix in the notice of proposed rulemaking of procedural and care guidelines as well as all required forms used in the long-term care survey process.

* Circulation to all regional offices and State survey and certification agencies of a detailed cross-reference guide to assist long-term care surveyors to correctly apply regulatory requirements to specific provider types.

* Training a cross section of Federal and State surveyors in the revised procedural and care guidelines and sampling procedures.

CHAPTER III

# ENCOURAGING COMPETITION AND CHOICE

## INTRODUCTION

HCFA continued during the fiscal year to place emphasis on providing Medicare beneficiaries with a choice of enrolling in prepayment health plans such as health maintenance organizations (HMOs) and competitive medical plans (CMPs). Prepayment plans are increasing in popularity among Medicare beneficiaries as an alternative to the traditional fee-for-service system for the delivery of health care services. The Medicare program has been contracting with HMOs since 1972, and in 1982 the Tax Equity and Fiscal Responsibility Act (TEFRA) expanded the definition of organizations eligible to enter into Medicare contracts to include CMPs. HMOs and CMPs may contract with HCFA on either a risk or a reasonable cost basis.

In FY 1987 the number of HMOs and CMPs with Medicare risk contracts increased from 143 to 157 and the number of beneficiaries enrolled in these plans increased 24 percent, to nearly one million. The majority of these beneficiaries enjoyed additional benefits not covered by traditional fee-for-service Medicare, including, for example, preventive care services, unlimited hospital days, and in certain competitive markets, the provision of prescription drugs and basic eyeglasses. The services were made available without regard to the frequency or extent of usage in return for predetermined, fixed premiums.

### Legislation Affecting HMOs and CMPs

OBRA 86 contained a number of provisions relating to the protection of Medicare beneficiaries enrolled in prepayment health plans. One provision implemented at the close of FY 1987 requires that PROs, and a new type of entity, quality review organizations (QROs), review the necessity, appropriateness and quality of care rendered by HMOs and CMPs to Medicare beneficiaries. Each HMO and CMP is required to enter into an agreement with the PRO or QRO serving its area to accomplish the quality review activities. The review panels are further charged with the responsibility of investigating beneficiary complaints about the quality of care provided by HMOs and CMPs.

OBRA 86 further provides that Medicare beneficiaries be allowed to disenroll from a prepayment plan at any Social Security office, and directs HMOs and CMPs to inform Medicare members annually of their rights and the limits of their coverage. It also requires HMOs and CMPs to meet the same standards for promptness in paying claims as those that apply to Medicare carriers and intermediaries. Medicare carriers and intermediaries are required to process 95 percent of claims received from non-HMO/CMP providers within 30 days of receipt as long as the claims are "clean" claims that do not require further documentation for adjudication. HMOs and CMPs are further affected by an OBRA 86 provision limiting waivers of the "50/50 requirement" to entities operated by governmental agencies, and then only for a 3-year period. The 50/50 requirement prescribes that no more than 50 percent of the members of an HMO or CMP with a Medicare contract may be Medicare or Medicaid beneficiaries. Waivers previously were available to a plan operating in a service area with an unusually large population of Medicare and Medicaid beneficiaries.

## HMO and CMP Oversight Activities

A detailed on-site monitoring protocol was developed and tested by HCFA during the fiscal year for the purpose of strengthening oversight of HMOs and CMPs. Central and regional office staffs are to employ the program to monitor compliance of the prepayment plans with statutory and contractual requirements.

Beneficiary services were advanced during FY 1987 with the development of the Beneficiary Inquiry Tracking System (BITS) to monitor the handling by prepayment plans of the inquiries and problems of Medicare members. Scheduled to be fully operational in FY 1988, BITS is intended to ensure a prompt response to beneficiary questions and a timely resolution of their disputes. The introduction of BITS was accompanied by the initiation of a survey of Medicare beneficiaries who disenrolled from prepayment plans. The survey was intended to determine the reasons for disenrollment and whether plan administrators were encouraging some beneficiaries to disenrollment because of the status of their health. Results of the survey also may assist HCFA in determining whether HMOs and CMPs are providing Medicare beneficiaries with an adequate explanation of membership rules when they first enroll. The survey will be tested and implemented in FY 88.

## International Medical Centers Termination

International Medical Centers (IMC) was a risk-contracting Medicare HMO serving more than 130,000 Medicare beneficiaries in the Miami and Tampa, Florida, areas. In May 1986, HCFA determined that IMC was not in compliance with statutory requirements. In spite of 36 inspection visits by HCFA officials during late 1986 and early 1987 the deficiencies persisted. Lack of compliance was cited in IMC's administrative and management practices, financial condition, and the ratio of Medicare to non-Medicare enrollees. After HCFA announced on May 1, 1987, its intent to terminate IMC's risk contract as of July 31, 1987, IMC was declared insolvent by the State of Florida Department of Insurance and placed in receivership. Humana Medical Plan, Inc., purchased IMC's assets on July 1, 1987, and entered into a contract with HCFA to continue to serve Medicare beneficiaries. More than 118,000 Medicare beneficiaries were brought under the coverage of the contract with Humana. The transfer was completed before the scheduled termination date of the contract with IMC, with HCFA taking the following actions:

* Immediate monitoring in conjunction with the Florida PRO of the quality of care provided by Humana.

* Establishment of bilingual toll-free telephone numbers perated by HCFA for beneficiaries to obtain information.

* Creation of HCFA task forces in Miami and Tampa to ensure beneficiary access to health care.

* Mailings in Spanish and English to all Medicare beneficiaries enrolled in IMC at the time HCFA notified the plan of its intent to terminate its contract assuring them that their Medicare coverage remained intact and apprising them of their options.

* Facilitating disenrollment from the plan, including the effectuation of disenrollment at local Social Security Administration offices.

* Arranging for affected beneficiaries to purchase Medicare supplemental insurance without waiting periods or exclusions for any pre-existing health conditions.

* Issuance of a notice-of-explanation to all IMC-affiliated physicians and Medicare-certified hospitals reminding them of their responsibility to continue to provide care to Medicare members of the plan.

**Improved Efficiency of Enrollment and Disenrollment Process**

The system used by HCFA to process prepayment plan enrollment and disenrollment data, the Group Health Plan System (GHPS), was designed more than 15 years ago to service a small number of prepayment plans. The capacity of the GHPS is being severely taxed as more Medicare beneficiaries enroll in prepayment plans and a greater number of plans elect to participate in Medicare. To meet this increased demand, HCFA initiated the GHPS Redesign Project during the fiscal year with intentions of implementing it over the next three fiscal years. Major phases of the project include the transfer of HMO systems capability and processing from the Social Security Administration (SSA) mainframe computers to HCFA computers, and making the major HCFA prepayment plan enrollment and disenrollment files more accessible to regional offices, Medicare providers, and participating prepayment plans.

**Improved Efficiency of Payment for HMO/CMP Contracts**

Plans for the redesign of the system used to make payments to all participating health care plans started to take shape at a meeting in early 1987 between HCFA staffers and representatives of the MITRE Corporation. Because the system was only semi-automated at the time, it was apparent that a major restructuring was necessary to handle the increased workload generated by the Private Health Plan Option. Following the initial meeting, a redesign plan was fashioned and implemented. The new system is fully automated with advanced security systems and the capability of making payments on a verified rather than an estimated basis.

**Initiative to Create Medicare Insured Groups**

Work continued in FY 1987 on planning a demonstration program to expand Medicare risk contracting to employers and unions that provide health benefits to their retirees. Under the Medicare Insured Groups (MIGs) demonstration, an employer or union would receive a monthly capitation for each Medicare beneficiary enrolled in a managed care plan sponsored by a MIG. The sponsoring employer or union would then assume medical and financial responsibility for providing both Medicare and other health benefits to its retirees. In turn, the employer or union would be paid 95 percent of the group's estimated Medicare costs, based on prior utilization. HCFA developed several technical assistance documents and held a series of meetings with employers, insurers, and unions to discuss the concept during the fiscal year. A number of large groups have expressed interest in the program, including the Amalgamated Life Insurance Company (ALICO), which submitted the first research and demonstration proposal to HCFA for participation in the MIGs demonstration program. A cooperative agreement between HCFA and ALICO is expected to be signed in the fall of 1987. At the same time, HCFA is making progress toward signing a cooperative agreement with the Chrysler Corporation and the United Auto Workers.

CHAPTER IV

# EFFICIENT OPERATION OF MEDICARE

## INTRODUCTION

Medicare contractors fulfill the Federal Government's responsibility of reimbursing Medicare beneficiaries and providers of service in a timely, accurate, and fiscally responsible manner. Fiscal intermediaries reimburse providers of services under Part A of the Medicare program, primarily for hospital inpatient activities. Their responsibilities encompass making and accounting for Medicare benefit payments, auditing the financial records of providers, making final settlement of cost reports, recovering any Medicare overpayments, and safeguarding the Medicare trust funds against payment for services that are not medically necessary. Carriers adjudicate claims and make payments to beneficiaries and providers of service under Part B of the Medicare program, primarily for physician services. Their responsibilities include receiving and accounting for Medicare benefit claims, accounting for payments made directly to and/or on behalf of eligible Medicare beneficiaries, determining allowable reasonable charges for medically necessary covered services, and computing and recovering overpayments in cases of erroneous payment. They also implement the participating physician program, establish methods to identify utilization patterns which deviate from medically accepted norms and report such deviations to the appropriate professional groups.

HCFA currently negotiates 89 contracts with intermediaries and carriers, including four experimental, fixed-price contracts. As part of its contract enforcement activities, HCFA monitors the contractors' expenditures, tracks savings realized from payment safeguard activities and productivity investments, and reviews contractor performance in paying claims, serving Medicare beneficiaries and assuring the fiscal integrity of the Medicare trust funds.

## DISTRIBUTION OF CLAIMS

Intermediaries received 67.2 million claims in FY 1987, a 5 percent increase above the FY 1986 level. Outpatient services accounted for 65.2 percent and inpatient hospital services for 216.8 percent of the claims. Home health agency and skilled nursing facility claims accounted for 7.6 percent and 1.1 percent, respectively. The remaining 9.3 percent were claims submitted for ancillary and other miscellaneous services payable under Part B. The cost to process these claims was $1.81 per claim. Carriers received 334.1 million claims in FY 1987, a 11 percent increase over the FY 1986 level. The percentage of claims submitted by physicians and suppliers on assignment increased from 68 percent in FY 1986 to 71.7 percent in FY 1987. The cost to process these claims was $1.65 per claim.

## PAYMENT SAFEGUARDS

In addition to processing payment claims for providers of service and Medicare beneficiaries, contractors perform other vital functions. These include conducting medical reviews of claims to ascertain whether services are medically necessary and constitute an appropriate level of care, auditing Medicare cost reports of providers, and assuring that under certain circumstances, Medicare is the secondary payer if the health care services rendered a Medicare beneficiary are covered by a private insurer. These payment safeguards accounted for savings of $2.9 billion for FY 1987 as follows:

| | |
|---|---|
| Medical Review/Utilization Review | $ .9 billion |
| Medicare Secondary Payer | $ 1.4 billion |
| Audit | $ .6 billion |

## PROSPECTIVE PAYMENT SYSTEM REFINEMENTS

Medicare operations associated with the prospective payment system (PPS) during FY 1987 focused on implementing provisions of OBRA 86. They made several changes affecting Medicare payments to hospitals, including an increase in the payment rate for inpatient hospital services, separate payment rates for cost outliers for rural and urban hospitals, and the revision of criteria for designation as a rural referral center.

To implement these provisions, HCFA developed a special computer software adjustment program to be used by Medicare intermediaries. It is designed to ascertain the proper adjustment amount for Medicare claims and to provide a listing by provider of total amounts to be reimbursed. Implementation of this special payment adjustment system is credited with saving the Medicare program $4.5 million in claims processing costs.

## OTHER REIMBURSEMENT POLICY ISSUES

### Implementation of the Medicare Secondary Payer (MSP) Provision for Disabled "Active Individuals"

OBRA 86 made Medicare a secondary payer for items and services provided after December 31, 1986, to disabled Medicare beneficiaries who qualify as "active individuals" and are enrolled in large group health plans (LGHPs). An "active individual" is defined in the law as an employee (as may be defined in regulations), the employer, an individual associated with the employer in a business relationship, and family members of any of the preceding individuals. The law applies to plans covering employees of an employer with 100 or more employees. During FY 1987, HCFA issued to intermediaries interim instructions containing rules for determining when Medicare is the secondary payer and the amount to pay in those instances. These instructions also specify the obligations of employers and LGHPs to pay primary benefits for "active individuals" and to reimburse Medicare where it had paid mistakenly as a primary payer. MSP provisions, which cost $56 million to administer, produced more than $1.4 billion in savings in FY 1987, for a cost benefit ratio of 1:25. Implementation of the new regional data exchange system (RDES) contributed to these savings by permitting Medicare contractors to share beneficiary information related to the MSP provisions.

### Ambulatory Surgical Procedures

A major HCFA operational effort during the fiscal year was the implementation of Section 9343 of OBRA 86 which enacted Section 1833(i)(3) of the Social Security Act to place a payment limitation on hospitals for certain surgical procedures that are also approved for ambulatory surgery centers (ASCs). Payment for these procedures must be based, in part, on what the Medicare program would have paid for the same surgery had it been performed in an approved ASC. Information generated by this activity will permit HCFA to accumulate a data base for the development of designs and models for an outpatient prospective payment system. Congress has directed the Secretary to provide such designs and recommendations for a system that would include all hospital outpatent surgical procedures (April 1, 1989) and one for all other hospital outpatient services (January 1, 1991).

### Home Health Agencies Assigned to Designated Regional Intermediaries

Section 2326(b) of the Deficit Reduction Act of 1984 (DEFRA) amended Section 1816(e)(4) of the Social Security Act to require HCFA to reduce the number of intermediaries designated to serve freestanding HHAs to no more than 10. This mandate reflected the belief that directing the HHA workload to fewer intermediaries would enable those intermediaries to process a workload volume large enough to gain expertise with this bill type and would lead to greater consistency in administering the home health benefit. On February 13, 1986, HCFA published a final notice designating 10 regional intermediaries to serve freestanding home health agencies. The notice named the States each intermediary is to serve and cited the general criteria used to select the intermediaries and the transition procedures applicable during the change-over period. More than 3,000 home health agencies were transferred to the designated intermediaries during the fiscal year.

### Reasonable Charge Screens for Nonphysician Services

Medicare's use of reasonable charges to determine reimbursement for physician services has been criticized as inherently inflationary because actual charges, which increase steadily, are one of the variables used for calculating reasonable charges. Effective January 1987, HCFA implemented the maximum allowable actual charge (MAAC) provision of the OBRA 86. The MAAC calculation limits the increase in nonparticipating physicians' actual charges to Medicare beneficiaries. HCFA monitors physician charges and reports violations to the OIG.

## IMPROVED OPERATIONAL EFFORTS

### Claims Processing Timeliness

Congress established new policies in Section 9311(b) and (c) of OBRA 86, which enacted sections 1816(c)(2) and 1842(c)(2) of the Social Security Act, for the timely payment of Medicare claims. Both Part A and Part B contractors were required as of the beginning of the fiscal year to pay at least 95 percent of all "clean" Medicare claims within 30 days. Since April 1987 contractors failing to meet the claims processing timeliness (CPT) deadlines have been required to pay interest on clean claims not paid within 30 days. HCFA supplemented these statutory provisions by requiring them to pay 95 percent of all claims within 60 days and 99 percent of all claims within 90 days. For Part A, eligible hospitals had periodic interim payments (PIP) discontinued as soon as CPT requirements were met by individual intermediaries for any three consecutive months, in accordance with Section 9311(a)(3) of OBRA 86. The 3-month period began in April 1987.

By the end of FY 1987, Part A and Part B contractors had achieved considerable success in complying with the CPT requirements. The requirement for paying at least 95 percent of all clean claims in 30 days was met by all but 3 intermediaries and 2 carriers. The 60- and 90-day requirements were met by 57 of the 58 Part A intermediary processing sites and 47 of the 48 Part B carrier processing sites. HCFA successfully removed approximately 2,000 hospitals from PIP by September 30, 1987. OBRA 86 assumed this action would produce a one-time savings of $2.9 billion.

For FY 1988, OBRA 86 mandates that all clean Medicare claims be paid within 26 days of receipt for Part A and Part B with the exception of claims from participating physicians. Clean claims from participating physicians are to be paid within 19 days of receipt.

### Contractor Performance Evaluation Program

HCFA evaluates the performance of Medicare contractors by using the Contractor Performance Evaluation Program (CPEP). CPEP incorporates numerous performance standards designed to reduce inappropriate expenditures through payment safeguards. In FY 1987, HCFA employed 36 discrete payment safeguard standards to evaluate intermediary performance in the areas of bill processing, medical review, and provider reimbursement. Twenty-five payment safeguard standards were used to evaluate carrier performance in the areas of claims processing and medical review. Selected standards included Medicare secondary payer goals, cost-effective medical review and audit programs, detection of fraud and abuse cases, limiting the incidence of provider overpayments, and ensuring that no payments are made to excluded, terminated or suspended providers or physicians. Contractors met 96.2 percent of all payment safeguard standards during the fiscal year. This was an improvement over the previous 12 months when contractors met only 91.6 percent of all payment safeguard standards.

### Replacement Contractors

Section 2326 of DEFRA provides for the replacement of up to two fiscal intermediaries and two carriers through competition of their service areas based on their performance over time against established cost and performance criteria. As the result of competition based on performance results from FY 1983 through FY 1985, Blue Cross and Blue Shield of Oregon became the intermediary in FY 1987 for the service area previously administered by Blue Cross of Idaho Health Service, Inc., and Aetna Life and Casualty Company became the carrier for the area previously serviced by the Equitable Life Assurance Society of the United States (now Equicor, Inc.) in New Mexico.

Based on the FY 1987 rankings, which encompassed performance results for FY 1984 through FY 1986, Blue Cross and Blue Shield of the National Capital Area under Medicare Part A was identified as a contractor for potential replacement. The contractor challenged the action, and as a result of a negotiated settlement, withdrew from the program. HCFA reassigned the workload to Blue Cross and Blue Shield of Maryland, Inc., and Blue Cross and Blue Shield of Virginia. Other contract actions during the fiscal year included (1) an addendum on performance to the Part B contract with Seguros de Servicio de Salud de Puerto Rico, Inc., and (2) recompetition of the fixed-price contract with Blue Cross and Blue Shield of Missouri for the administration of the Medicare Part A contract in the State of Missouri.

### Common Working File

In FY 1987, HCFA had two operational commmon working file (CWF) sites—Maryland Blue Shield and Texas Blue Shield. The fundamental objective of the CWF system is to simplify, speed and improve the processing of Medicare claims. In advancing this objective, HCFA plans to create a hierarchically distributed processing system based on a series of localized data bases (host sites), each serving a network of contractors (satellite sites) within defined geographical areas. Host sites will maintain beneficiary-specific files containing complete entitlement, utilization and history data. All Part A and Part B claims then will be processed against this single file. Contractor operations are simplified through the elimination or reduction of processes such as query/reply, admissions notices, batch clearances and payment records. Enhanced protection for benefit funds is achieved, in part, through prepayment A/B history reviews, expansion of the base to check for duplicate claims, immediate Medicare-secondary-payer-status updates and reductions in adjustment processing (and, thus, overpayment recovery actions). While the CWF derives program savings from the increased accuracy and currency of its files, it does not dictate claims processing timeliness.

### Standard System

A major initiative of HCFA is to maximize the use of standard claims processing systems to reduce administrative costs and more readily implement legislative requirements. Four Part A standard processing systems—the Arkansas, California, Utah, and McDonnell-Douglas Corporation systems—were used in FY 1987 and soon will process nearly 40 percent of the Part A workload. All four systems use shared maintenance, and the Utah System uses shared processing. Experience shows that significant administrative savings can be realized through a shared maintenance arrangement.

With respect to Part B standard processing systems, HCFA developed a pilot program with The Travelers for the purpose of determining the feasibility of standard systems in Part B for realizing the same benefits achieved for the Part A systems. Following an evaluation of the results of the pilot program scheduled to be put in operation in February 1988, a Part B standard system strategy will be determined.

### Medicare Benefit Notice Service Upgrade

An improved system for preparing and mailing notices to Medicare beneficiaries was introduced during the course of the fiscal year with the result that beneficiaries now receive notice of a Medicare payment within 2 weeks, or 5.5 times faster than under the old system. Speedier and easier processing of the notices was achieved by transferring from the SSA central electronic data processing facility to HCFA the responsibility of preparing the notices. Under the old system, SSA prepared the notices from tapes that Medicare intermediaries mailed to the SSA central facility.

### Improved Home Health Review

HCFA continued to improve the accuracy and consistency of intermediary home health determinations. Quarterly meetings were held with regional home health intermediaries to improve their efforts. HCFA also developed a series of home health case studies for intermediary guidance. The home health data-set used by Medicare intermediaries to make coverage decisions was based on home health industry efficiency recommendations.

### Medicare Carrier Local and Toll-Free Telephone Service

Medicare carriers were reminded during the year of the importance of the requirement that they provide local and toll-free telephone service to Medicare beneficiaries. Carriers must meet busy signal and call acknowledgement standards for telephone service, and are required to install telephone monitoring equipment to electronically monitor telephone service performance. Monthly reports of performance are required, and if a carrier does not meet minimum standards, corrective action is taken by the appropriate HCFA regional office. In FY 1987, carriers maintained an average 11.4 percent all-trunks-busy (ATB) level of service against a standard of not more than 20 percent ATB.

### Beneficiary Inquiry Workloads at Carriers and Intermediaries

During FY 1987, Medicare carriers handled16,203,604 beneficiary inquiries (13,359,088 telephone, 2,385,088 written, and 459,428 walk-in). This represented a 9.7 percent increase in beneficiary inquiries over FY 1986. Carriers also handled 6,583,087 provider inquiries (3,776,666 telephone, 2,788,483 written, and 17,983 walk-in). This represented a 16 percent increase in provider inquiries over FY 1986. Beneficiary and provider inquiries in FY 1987 totaled 22,786,922.

Medicare intermediaries handled 1,571,085 beneficiary inquiries in FY 1987 (1,162,600 telephone, 359,572 written, and 48,913 walk-in) and 1,498,217 inquiries from providers (727,632 telephone, 768,530 written, and 2,055 walk-in). Beneficiary inquiries to intermediaries decreased by 4.6 percent in FY 1987.

### Denied Claims Review

After denial of a Part A claim, a claimant has the right to reconsideration by the intermediary of the denial. If the claim is again rejected, the claimant may request a hearing and subsequent review before an administrative law judge (ALJ) and the Appeals Council, respectively, within the Social Security Administration. During FY 1987 there were 72,843 reconsideration requests, an 111 percent increase over the number of reconsiderations in FY 1986. At the same time, the number of ALJ hearings rose 30 percent, to 1,867. Forty-four percent of the hearings resulted in reversals of earlier rulings.

For a denied Part B claim, a claimant has the right to a carrier review, a carrier hearing, and, for claims for services on or after January 1, 1987, a hearing before an ALJ. In FY 1987, carriers reviewed 5.4 million denied claims, an increase of 20 percent over the FY 1986 level. Of those reviewed, 59 percent resulted in reversals. Carrier hearings during the fiscal year numbered 34,439, an increase of 36 percent over the FY 1986 level. Sixty-four percent of the hearings resulted in reversals.

### Participating Physician Program

DEFRA 84 created the participating physician program under which physicians and suppliers may make a voluntary choice each year to accept assignment on all Medicare claims for the following year. Those who accept assignment agree to accept Medicare approved amounts as payment in full for their services regardless of the actual charges. On assigned claims, they bill the beneficiary only for applicable deductible and coinsurance amounts.

COBRA 85 and OBRA 86 provided incentives for physicians and suppliers to participate in Medicare, including a 4 percent reduction in prevailing charge levels for non-participating physicians and suppliers, and informational and referral activities such as directories and toll-free telephone numbers to facilitate beneficiary use of participating physicians. For the most recent participating period, extending from January to December 1987, 30.6 percent of the physicians (159,091) and 18.6 percent of the suppliers (14,052) signed participation agreements.

To promote the program, HCFA mailed notices in April 1987 to the more than 32 million beneficiaries explaining the participating physician/supplier concept and noting the availability of participating physician/supplier directories. The directories may be obtained free-of-charge from Medicare carriers, or reviewed at Social Security Administration, Railroad Retirement Board, senior citizen organization, and Area Agency on Aging offices.

### Carrier Medical Review

Ensuring that Medicare payment is made only for reasonable and necessary physician services is the responsibility of the Medicare carriers. Carriers execute this responsibility through a blend of prepayment review of individual services and postpayment review of utilization patterns of physician and supplier services. The carrier determination is based on national coverage policy, augmented by local policy developed by the carrier medical staff. This activity has been cost-effective, with FY 1987 program savings of approximately $8 for each administrative dollar expended.

### Electronic Claims

Intermediaries received more than 46 million and carriers approximately 103 million electronic claims during the fiscal year. The goal to increase the percentage of electronic media claims (EMC) to 65 percent for intermediaries and 30 percent for carriers was surpassed as intermediary and carrier EMCs reached 72 percent and 33.2 percent, respectively, for FY 1987. The cost of processing the EMCs was about $57 million less than what it would have cost to handle the same number of paper claims.

### Development of Automated Systems

HCFA operates and maintains an automated system that gathers information on the actual amounts and causes of provider overpayments and associated interest, the recoupments, and the time associated with recovery. This system utilizes a nationwide telecommunications network linking HCFA's central office with its regional offices and fiscal intermediaries. During FY 1987, provider overpayment average quarterly balances decreased by $66 million, a 24 percent reduction over the previous year's amount.

### Operational Reviews

Operational reviews are designed to determine whether established policy and operational criteria are effectively met, to thoroughly evaluate the appropriateness and cost-effectiveness of selected HCFA-wide operational procedures and systems, and to supplement available data with additional documentation and understanding of program problems.

Operational reviews undertaken during the fiscal year included surveys of physician payment levels associated with cataract surgery, permanent pacemaker implantations, and transurethral resection prostatectomies (TURPs). The appropriateness and financial impact of the laboratory fee schedules were also the subjects of review as were the decisions of some fiscal intermediaries in denying home health agency claims for patients discharged from hospitals. A review was also begun to determine if hospitals were submitting claims for inappropriate and/or noncovered outpatient services in four selected service categories.

### Physician Payment Studies

The following studies were initiated during the fiscal year to explore methods for controlling the growth in spending for physician services:

* Cataract:

  In FY 1986, a study of physician fees associated with cataract surgeries was completed. This study compared cataract surgical procedures with insertion of an intraocular lens to cataract surgical procedures without insertion of an intraocular lens.

  The results of the study were used to support a legislated 10 percent reduction in Medicare's approved amount for cataract surgery. This action saved Medicare at least $50 million in FY 1987. A three-phase follow-up study was under taken that involves defining and/or bundling a standard package of services (pre- and post-operative) for a typical Medicare benefi ciary for cataract and coronary artery bypass graft (CABG) procedures. Phase I, completed in FY 1987, involved establishing the physician billing and carrier payment practices for the surgeries.

* Transurethral Resection of the Prostate

  A study of TURP procedures demonstrated that while the time necessary to perform the procedure decreased during theperiod from 1971-1986, there was no indication of a corresponding reduction in physician fees for the service. The study was conducted from August through October 1987, at 50 randomly selected hospitals.

**Hospital Outpatient Study**

A hospital outpatient study was begun in FY 1987 to determine if hospitals were billing for inappropriate and/or noncovered outpatient services in four selected categories (emergency, laboratory, radiology and physical therapy), and to determine the appropriateness of fiscal intermediary coverage and medical-necessity decisions relative to hospital outpatient billings. The study, scheduled for completion in FY 1988, is based on services provided to Medicare beneficiaries in FY 1986 when the four selected categories of service represented 55 percent of the total covered charges for Medicare outpatients. It involves 10 fiscal intermediaries, 40 hospitals, more than 1,500 claims for services, and more than 200 visits to physicians' offices. The claims are under review by board-certified physicians in appropriate specialties to determine if the services provided were medically necessary.

**Laboratory Fee Schedule**

Another study, focusing on the laboratory fee schedule, was conducted in FY 1987 to demonstrate the specific nature and extent of variations in the schedule of laboratory fees paid by Medicare carriers. All carriers were involved and the 25 most frequently billed laboratory procedures were evaluated.

The study found that: (1) there were large variations in payments for multi-channel tests even after implementation of the CAP that was legislated at 115 percent of the Medicare-wide payments, (2) there was little uniformity in the composition of multi-channel tests and, even when tests were different, the differences did not justify the large payment variations observed, (3) the prevailing charges, on which fee schedules are based, reflect billings not only from independent laboratories but from physicians billing under arrangements with laboratories (before DEFRA), which could cause large variations in billed charges and, (4) the screening of claims by carriers has resulted in significant dollar savings.

**Rebasing and Reweighting of the National Hospital Input Price Index**

The National Hospital Input Price Index (hospital market basket), which was last updated in 1977, was rebased in FY 1987. The significance of the update is that the index cost weights are used to determine appropriate update factors for the Medicare prospective payment system and the hospital rate-of-increase limit. To better ensure the financial integrity of the health care system, it is essential that these payment guides accurately reflect the cost and mix of goods and services that hospitals purchase. The rebasing coincided with the five-year economic cycle report compiled by the Bureau of Economic Analysis (BEA), Department of Commerce, and was consistent with the recommendation of the Prospective Payment Assessment Commission (ProPac) that HCFA observe a five-year rebasing and reweighting cycle. Using the BEA data and data from a 1983 survey by the American Hospital Association, the hospital market basket was rebased to reflect 1982 rather than 1977 data. In the process, the number of categories was expanded from 18 to 28, and modified variables were used as price proxies to better refine the relative importance of costs used to establish the input weights.

### Revision of Diagnosis Related Groups Classifications and Weighting Factors

Major DRG classification revisions introduced during FY 1987 included the establishment of a separate DRG for certain extensive burn cases and a revamping of many surgical hierarchies among DRG categories. These changes were accompanied by improvements to numerous DRG procedure classification routines and logic issues as recommended by ProPAC.

### Revisions of Standardized Rates to Reflect Different Outlier Payments Among Urban and Rural Hospitals

The PPS legislation required separation of the determination of the offset of PPS payments attributable to estimated outlier case payments due to the different experience of such cases for urban hospitals and rural hospitals. Due to this legislative requirement and the total payment budget baseline, the change results in less of a reduction to standard payment rates for rural hospitals in recognition of the fact that they have fewer outlier cases.

### Referral Center Criteria

Reforms implemented during the fiscal year in accordance with both legislative and regulatory requirements reduced the level of discharges and case mix index needed for a rural hospital to qualify as a referral center. This resulted in the qualification of more than 60 additional hospitals as referral centers and necessitated adjustments to the PPS standardized amounts to ensure continued budget neutrality.

### Disproportionate Share Adjustment for Rural Hospitals

Changes for PPS hospitals that service disproportionate shares of low income patients were included in OBRA 86. Consistent with the threshold established for large urban hospitals to receive the disproportionate share adjustment to their PPS payments, HCFA set the criteria for rural hospitals with 500 or more beds at 15 percent low-income patients. The PPS standardized rates were not adjusted for this rate, however, since the fiscal impact was expected to be minimal.

### Rate of Increase in PPS Payment and Rate-of-Increase Ceilings

OBRA 86 provided for an increase of 1.15 percent in the standardized amounts and the hospital-specific amounts under PPS and to the rate-of-increase limits applicable to hospitals and units excluded from PPS. The increase was retroactively adjusted for all of FY 1987.

### Medicare Heart Transplant Centers

Eight hospitals meeting special criteria established by HCFA were approved by the agency late in the fiscal year as Medicare heart transplant centers. The designations were based on the recommendations of outside consultants and made retroactive to October 17, 1986. The following hospitals were approved: the Medical College of Virginia, Richmond, Virginia; Stanford University Hospital, Stanford, California; University of Minnesota Hospital and Clinic, Minneapolis, Minnesota; University of Arizona Health Sciences Center, Tucson, Arizona; Johns Hopkins Hospital, Baltimore, Maryland; Foster G. McGaw Hospital-Loyola University Medical Center, Maywood, Illinois; Methodist Hospital-Baylor College of Medicine, Houston, Texas, and Methodist Hospital of Indiana, Indianapolis,

Indiana. The notice announcing HCFA's intention to designate Medicare heart transplant centers was published in the October 17, 1986, issue of the Federal Register, and the final notice appeared in the April 6, 1987, issue.

CHAPTER V

# RESEARCH, DEMONSTRATIONS AND EVALUATIONS

## INTRODUCTION

For a substantial period of time the cost of health care has outpaced the rate of inflation in the general economy. Consequently, the absolute number of dollars spent on health care has risen rapidly, as has the proportion of the Gross National Product (GNP) related to health care. This trend continues to be a matter of primary concern to HCFA as the leading purchaser of health care in the United States. Since the establishment of HCFA, the overall purpose of its research and demonstration (R&D) program has been to find ways to moderate or control inflation in health care costs and to ensure that every Medicare dollar is used effectively in the service of beneficiaries.

HCFA's R&D activities provide knowledge to enable the Administrator, the Secretary, the Congress and other interested parties to make informed and rational decisions regarding HCFA programs and policies. Current research, demonstration, and evaluation activities include projects to test new reimbursement, coverage, eligibility, and program management approaches as well as research and evaluation studies of the impact of HCFA programs on health care costs, program expenditures, beneficiary access to quality health care services, and the economics of the health care industry. HCFA is extensively involved in the creation of new and improved data sets to support these ongoing research and demonstration activities. These projects result in knowledge about the basic structure, incentives, costs, and effects of HCFA programs and policies and make it possible to refine existing policies, simulate or test various program changes on a trial basis, and develop innovative financing and delivery systems.

Besides funding various intramural projects, HCFA spent nearly $28 million in FY 1987 for grants and contracts to conduct research, demonstration and evaluation projects in seven program areas: alternative payment systems, quality of care, physician payment, hospital payment, program efficiencies, analysis and refinements, beneficiary awareness and prevention, and subacute and long-term care. (More specific information about individual projects in 1986 can be found in the Health Care Financing Status Report: Research and Demonstrations in Health Care Financing U.S. Department of Health and Human Services. HCFA 03253. Washington, D.C.: Government Printing Office, 1986). In addition to the preceding activities, OBRA 86 required establishment of an agenda for R&D projects related to rural and inner-city health issues and an annual report to Congress regarding these initiatives. Specific steps for addressing this mandate are under development.

## ALTERNATIVE PAYMENT SYSTEMS

Prior research and demonstration activities involving the Medicare program focused primarily on HMOs. This work determined that alternative delivery systems and alternative risk reimbursement mechanisms are cost-effective and offer Medicare beneficiaries the opportunity for improved benefits over the existing fee-for-service system. With the implementation of the HMO provisions of TEFRA 82, there was a need to go beyond HMO and

CMP models and test other delivery and financing systems that enhance competition among providers and potentially yield savings to the program. This involves the development and evaluation of demonstrations with employers and unions to provide their retirees a Medicare benefit package. The Medicare insured group (MIG) demonstrations are designed to:

* Provide alternatives to traditional fee-for-service Medicare to natural groupings of beneficiaries.

* Encourage cost-effective, well managed, high quality care.

* Enhance competition among all providers of medical care.

* Develop appropriate group-related payment methods.

Several other areas are also involved in studies of alternative payment methodologies, such as hospital payment, physician payment, and State programs for long term care. However, projects tend not to be limited to one segment of the Medicare population or to one aspect of the health care delivery and financing systems. Within this area, researchers attempt to identify, test, and evaluate cost-effective alternative delivery and/or financing systems which impact on multiple segments of the program. Therefore, the agency focused on those projects designed to test systems capitating payments for various types of services and those which tried to refine or test alternatives to the current methods and bases for payments to capitated systems.

Thirty-five studies that have tested alternative reimbursement methods continued in FY 1987. For example, HCFA forged ahead with evaluations of the most recent series of HMO demonstrations and began planning for an evaluation of the TEFRA HMO and TEFRA CMP programs. The following ongoing demonstrations all test various innovative concepts:

* A reimbursement method that takes into account a beneficiary's prior use of Medicare services as an additional factor in the adjusted average per capita cost (AAPCC) methodology.

* Three HMOs located in competitive marketing areas receive reimburse ment at 85 percent of the AAPCC, rather than the TEFRA-mandated 95 percent.

* The social health maintenance organization (S/HMO) concept studies a capitated delivery and financing system that integrated health and social services under the direct management of the provider of services.

There were two major continuing research activities during FY 1987:

* Research was completed on the initial development of the Diagnostic Cost Group (DCG) model for adjusting HMO payments. This model uses diag nostic information from prior hospital stays.

* A panel of outside experts was convened to review a report prepared by the actuarial firm of Milliman and Robertson. After the review, which

focused on ways of improving the AAPCC, the panel made recommendations to the Secretary of Health and Human Services.

New initiatives during the year included:

* A study to examine whether and how DRGs and ambulatory visit groups (AVGs) would need to be modified for\outpatient surgery and other related issues involved in developing a prospective payment system for outpatient surgery.

* A study to develop a methodology for producing unbiased estimates of the degree of biased selection present among HMO enrollees.

* A project to develop a method for classifying patients that will predict resource requirements and measure outcomes of Medicare patients in HHAs.

## QUALITY AND COVERAGE

Program changes have the potential to impact on the quality of care provided to program beneficiaries. In order to assess the impact of such changes, as well as to ensure continued access by program beneficiaries to quality care, it is essential that valid quality-of-care measures for different treatment settings be developed. For this reason HCFA funded the following five new quality and coverage studies in FY 1987:

* Evaluating Outcomes of Hospital Care Using Claims Data (Dartmouth Medical School). This study, co-funded with NHS' National Center for Health Services Research and Health Care Technology Assessment, examines the use of claims data for evaluation of outcomes associated with surgical procedures and medical admissions. That would go beyond previous related research by examining a wider range of procedures and admissions, and byvalidating and interpreting previous findings through the comparison of claims data with medical records. Using data from Medicare and the Manitoba Health Commission, the project will proceed in two phases: testing of the hypotheses about the relationship between therapy and outcome for a subset for conditions and procedures, and validating the outcomes for alternative approaches to prostatectomy.

* Patient Classification Systems: An Evaluation of the State-of-the-Art (Queen's University, Kingston, Ontario). This project will compare the predictive power for costs and death of seven patient classification systems: acute physiology and chronic health evaluation (APACHE), clinical staging, computerized disease staging, computerized severity index, medical illness severity grouping system, patient management categories, and a revised DRG system. The study will abstract data from a nationally representative sample of approximately 25,000 records, and the classification systems will be compared individually and in various combi nations.

* Strategies for Assessing and Assuring Quality of Care in the Medicare Program (National Academy of Sciences, Institute of Medicine). A panel appointed by the Institute of Medicine initiated work on a study plan mandated by Section 9313(d) of the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509). This mandate provided that the Secretary arrange for a study to design a strategy for reviewing and assuring the quality of care

for which payment may be made under Title XVIII of the Social Security Act. The Secretary is further required to report the findings of this study, along with recommendations for strengthening quality assurance activi ties, to Congress.

* An Automated Data-Driven Case-Mix Adjustment System for Studies of Quality of Care (University of California at San Francisco). This project will investigate whether predictors of patient outcome for use as control variables in studies of quality of care can be developed from readily avail able laboratory test information. The project will develop predictors of the outcomes of hospital care using laboratory test results available in computerized form at many hospitals. The outcome variable will be mortality after hospitalization. Once developed, the models will be compared with those using variables obtainable only by labor-intensive review of medical records.

* Trends in Patterns of Post-Hospital Service Use and Their Impact on Outcomes (Duke University). This project will examine the pattern of care delivered to patients after their discharge from a hospital. They will be distinquished by diagnosis, age, sex, and other data elements con tained on the Medicare Part A bill. Post-hospital use patterns will be examined in terms of types and duration of Medicare services received and the proportion of patients receiving care. Similar patterns will be examined for non-hospitalized Medicare beneficiaries.

There are many relevant issues within the quality of care area, and HCFA has a continuing interest in such issues as they relate to: (1) the impact of payment mechanisms, such as the prospective payment system or the end-stage renal disease composite rate, on quality of care; (2) the impact of severity of illness on health care outcomes; (3) the effectiveness of alternative medical interventions on the health of Medicare beneficiaries, and; (4) access to and quality of services in subacute care settings, such as at home and in a skilled nursing facility. HCFA has 41 studies in progress in these areas.

## PHYSICIAN PAYMENT

HCFA's physician payment research agenda is based on a commitment to better understand the underlying reasons for the rapid growth in Medicare spending for physician services and to reform the current system. The research is intended to support proposals for reform of Medicare physician payment policy and reflect the increasing interest of Congress in developing a more rational payment system. It can be generalized into several priority areas, such as the issues of price, volume and intensity, practice costs, alternative payment systems, effectiveness, and access.

In FY 1987, a number of external projects and internal studies were completed that were extensively used in the Secretary's report to Congress entitled, Paying Physicians: Choices for Medicare. It suggested key elements for Medicare physician payment reform based upon competitive consumer choices. In addition, three studies were completed that figure prominently in the Secretary's report to Congress entitled, A Prospective Payment System for Radiology, Anesthesia and Pathology Services Furnished to Hospital Inpatients.

Although long-term growth trends in Medicare physician spending slowed somewhat between fiscal years 1984 and 1986, spending in this area rose sharply during FY 1987 and required the largest increase ever in Medicare Part B premiums. To better understand the cause of the increase in Medicare physician spending, HCFA is devoting more external and internal resources to physician payment research. To this end, a number of new studies were implemented to address mispriced procedures and what Medicare should pay for surgical procedures, to assess the impact of the Medicare fee freeze on physicians, to develop a geographic cost-of-practice index, and to better understand volume and intensity of service issues.

Major studies of resource-based, relative value scales continued, as did projects supporting improvements of Part B data. A program of focused short-term policy studies was initiated through HCFA's research centers and considerable indirect support was provided to the staff of the newly formed Physician Review Commission.

## HOSPITAL PAYMENT

HCFA continued to investigate issues related to the refinement and expansion of PPS during FY 1987, the fourth year of prospective payment. Three new extramural hospital payment research studies were awarded:

* Prospective Payment System Impact on Rural Hospitals (Center for Health Economics Research). This project will include descriptive analy ses of the performance of rural hospitals during the period 1980-86 and an econometric study of factors that affect their financial status. Case studies in nine areas across the country are also planned to focus on the rural hospital environment, the problems faced by rural hospitals and their responses to those problems. The results of this project are to be used to assist in the development of options for addressing the problems they face under PPS.

* Developing and Evaluating Options for Pediatric Prospective Payment Systems (Boston University Hospital). This project will include an evalua tion of the revised children's diagnosis related groups (CDRGs) developed by the National Association of Children's Hospitals and Related Institu tions under an earlier study funded by HCFA. In addition, an attempt will be made to develop adjustments that might be required in order to implement a prospective payment system for pediatric hospital services under Medicare or State Medicaid programs.

* Toward Prospective Payment for Outpatient Department Surgical Ser vices (Urban Institute). This two-year project will examine relevant pricing issues through various analyses, including an identification of factors responsible for the variation in the cost of surgery in different facilities and types of settings (i.e., hospital inpatient, hospital outpatient, ambulatory surgical centers and physician's office).

Besides these new studies, about 30 other extramural hospital payment studies begun in prior years continued into FY 1987. Discussed in detail in previous annual reports, they focus on a range of hospital payment issues, including the analysis of the impact of PPS, the

refinement of the patient classification system, the extension of PPS to other types of hospitals, and development of a prospective payment system for outpatient care.

Intramural research being conducted at HCFA has addressed many hospital payment issues, such as malpractice costs, the cost of medical education programs, payments for outlier cases, methods for incorporating capital costs into the PPS payment rates, and the recalibration of the DRG relative weights.

## PROGRAM EFFICIENCIES, ANALYSIS AND EVALUATIONS

Congress has prompted major changes in the past few years to improve the effectiveness and efficiency of the Medicare program. Research on and evaluation of these changes, as well as on factors influencing program performance, provide the information on health care expenditures and utilization patterns of Medicare beneficiaries necessary to achieve more cost-effective program operations. Essential to this effort is the improvement of existing Medicare data bases. Several aspects of program performance have been studied for the purpose of gaining a better understanding of the factors influencing utilization of particular types of services, of the characteristics of certain categories of beneficiaries, and of the characteristics of certain aspects of the programs. Among the ongoing projects are studies of the:

* Use of Medicare services in the last years of life.

* Geographic variation in medical use and costs to better understand fac tors influencing utilization patterns and factors influencing costs of services.

* Cross-over population that uses Medicare and Medicaid to better under stand the characteristics of this segment of the Medicare and Medicaid populations.

* Impact of Cyclosporine on the cost and outcomes of kidney transplanta tions.

* Economic consequences of acquired immune deficiency syndrome (AIDS) and AIDS-related complex for the Medicare and Medicaid programs.

* Impact of dializer re-use on patient mortality, morbidity, and kidney transplantation, and the effect of composite rate and nephrologists' pay ments on costs, access, quality, and resource use associated with the care of kidney patients.

## BENEFICIARY AWARENESS AND PREVENTIVE CARE

Current coverage rules governing Medicare do not allow reimbursement for most preventive services. HCFA, however, continues to maintain an interest in the potential beneficial effects of particular preventive medical services through its research. The two six-year prevention projects that were funded as a result of a special solicitation published in 1983 are continuing. In addition, Section 9314 of COBRA 85 requires that the Secretary estab-

lish and conduct a four-year demonstration program designed to reduce disability and dependency through the provision of specific preventive health services to Medicare beneficiaries. The projects are to be evaluated to determine the short- and long-term costs and benefits of providing preventive health services, and recommendations are to be made about what practical mechanisms exist to finance preventive health services under Medicare. A special solicitation for these projects has been published and it is anticipated that the demonstration will be conducted at five sites, one of which will be a rural area.

## SUBACUTE AND LONG-TERM CARE

Since it is expected that the costs of subacute and long-term care will continue to grow, HCFA maintains ongoing research and demonstrations in these areas in an effort to identify methods of effectively containing costs without adversely affecting the qualify of care. Several reports were submitted to the Congress in FY 1987 describing the results of demonstration projects conducted in previous years. One explained the evaluation findings concerning the Aid to Families with Dependent Children Homemaker/Home Health Aid Demonstration; another summarized the results of multiple demonstration projects that examined the costs and benefits of alternative approaches to paying for additional home- and community-based, long-term care services under the Medicare and Medicaid programs. Another report, prepared during FY 1987 and to be delivered to Congress during FY 1988, discusses the first 30 months of operations for the S/HMO demonstrations.

Developmental work was initiated by HCFA during the fiscal year on several new demonstrations required by Congress. In response to an OBRA 86 mandate, a contract was awarded to design the Medicare Alzheimer's Disease Demonstration to test the costs and benefits of providing additional coverage for home and community-based services for victims of Alzheimer's disease and related dementias. The study will examine the characteristics of cognitively impaired elderly persons in the community who suffer from Alzheimer's disease and related disorders. The demonstration design will be finalized and project sites selected during FY 88.

Several new demonstration projects were initiated in the interest of exploring the potential for development of new reimbursement approaches for Medicare home health services. Two projects were introduced to collect patient-level data covering Medicare home health patients. These projects will provide important information in the future about the case mix of home health patients and the feasibility of developing case-mix based payment systems for home health services. Pursuant to OBRA 87 HCFA also began design work late in the fiscal year on a demonstration project to test prospective payment methods for HHAs. In accordance with an OBRA 86 directive to test prior and concurrent authorization by Medicare fiscal intermediaries of HHA and SNF services, HCFA awarded a contract for an evaluation of an HHA concurrent authorization pilot project implemented in July 1987. The contractor also will design and evaluate a subsequent demonstration testing prior and concurrent authorization for SNF services.

Long-term care research projects initiated during the fiscal year included:

> Natural History of Post-Acute Care for Medicare Patients (University of Minnesota, School of Public Health.) This is a study of the course and outcomes of post-acute care, including SNF, home health, and rehabilitation services. It has two major components: analysis of Medicare data to assess differences in patterns of care across the country and to determine the extent of substitution where vari-

ous forms of post-acute services are more or less available, and detailed examination of clinical cases from the most common DRGs receiving post-acute care in three selected locations (Minneapolis, Pittsburgh, and Houston). Measures of the complexity of the clinical cases will be developed using a modification of the medical illness severity grouping system (MedisGroups). This project is jointly funded with the Office of the Assistant Secretary for Planning and Evaluation.

Study of Home Health Care Quality and Cost Under Capitated and Fee-for-Service Payment Systems (Center for Health Policy Research, Denver, Colorado). This study will compare the quality and cost of home health care provided under capitated and noncapitated payment systems for two groups of Medicare beneficiaries: clients admitted to home health care following a hospitalization, and those who have not been in a hospital for at least 30 days prior to the initiation of home care. Process and outcome quality measures will be developed and used with patient-level resource-use measures to assess cost effectiveness of care in the two settings.

Analysis of State Systems for Providing Intermediate Care Facility for the Mentally Retarded (ICF/MR) Services and Other Care for the Mentally Retarded (University of Minnesota, Center for Residential and Community Services). This project will update information on the status and charges in residential services for the mentally retarded gathered for 1977 and 1982 in a previous HCFA grant. Data on the current status of the ICF/MR program, which were obtained through the Inventory of Long-Term Places, the sampling frame for the institutional component of the National Medical Expenditures Survey, will be analyzed and supplemented by case studies of 10 States' programs for serving the mentally retarded.

Texas Nursing Home Case-Mix Demonstration (State of Texas). The Texas Department of Human Services will conduct a three-year demonstration to implement and evaluate a prospective case-mix payment system in a sample of Texas nursing homes. The goals of the project are: to match payment rates to resident need; to promote the admission of heavy-care patients to nursing homes; to provide incentives to improve the quality of care; to improve management practices; and to demonstrate administrative feasibility of the new system.

In recent years HCFA has funded several projects aimed at developing case-mix adjusted payment methods for Medicare and Medicaid nursing home patients. Based on these prototypes HCFA is developing a major national demonstration in four to six States that will integrate case-mix adjusted payment systems with data-driven quality assurance systems for nursing homes. Preliminary inquiries show a high level of interest from more than 40 State Medicaid programs. This developmental initiative will be completed in FY 1988 with site selection in FY 1989. The development of improved measures of the quality of home health care is another research priority, and HCFA has funded several research projects addressing this issue from various perspectives. Preparatory work was begun for a contract to be awarded in FY 1988 that will explore feasibility and desirability of developing measures of the quality of Medicare home health services that are based on patient outcomes.

Chapter VI

# PROMOTING IMPROVEMENTS IN HCFA

## INTRODUCTION

During FY 1987 HCFA management implemented the delegation of leasing authority (DOLA) for all HCFA-occupied buildings, revised the Agency's internal control program, introduced a two-year management training program for high-potential employees, and intensified efforts to attract highly qualified job applicants. It also registered gains in the area of equal employment opportunity, signed cooperative education agreements with various universities, and hired several graduate students from schools participating in the Presidential Management Intern Program. The Agency also surpassed FY 1987 targets in 6 procurement categories in the awarding of $60-plus million in contracts.

### Procurement Goals

HCFA exceeded departmental procurement preference and competition goals in the awarding of more than $60 million in contracts during FY 87. A summary of the goals and HCFA's actual performance in each of six procurement categories is as follows:

| Category | Goal | Actual | Total Dollars |
|---|---|---|---|
| 1. Small Business | 52.2% | 54.54% | $19,086,638 |
| 2. 8 (a) | 25.0% | 31.56% | 11,045,975 |
| 3. *Direct Minority | 1.0% | 2.04% | 714,715 |
| 4. Women-owned Business | 7.1% | 7.06% | 2,473,223 |
| 5. Labor Surplus Area | 7.1% | 10.38% | 3,634,236 |
| 6. Competitive | 80.0% | 81.91% | 23,463,749 |

* Because there is no mandated set-aside for direct awards to minority firms, achievement of this goal was primarily dependent upon the minority vendors submitting proposals for and winning competitively bid contracts.

### Internal Control Program

The agency's internal control program was improved during the fiscal year with the implementation of the provisions of the Office of Mangement and Budget's (OMB) revised circular A-123, Internal Control Systems. This initiative involved, among other things, the division of the agency into 55 internal control areas and the decentralization of administrative functions to give line managers active roles in the conduct of internal control reviews (ICR). In conjunction with this reorganization final reports were completed on 18 ICRs conducted in 1986 and 4 ICRs conducted in FY 1987.

### Facilities and Space Management

Also successfully undertaken during the fiscal year was the implementation of the DOLA for all HCFA buildings. This involved discussions with SSA relative to the East High Rise and East Low Rise buildings in Baltimore and the fulfillment by SSA of the DOLA responsibilities for these two buildings. Other space management activities during the fiscal year

included nine moves affecting 10 percent of the agency's personnel. The moves were necessary to bring HCFA into conformity with the space requirements of the department and the General Services Administration (GSA).

### Management Development Program

Recognizing the need to train high-potential employees for future management positions, HCFA introduced an agency-wide program to identify and prepare qualified candidates for managerial roles. Nine employees were competitively selected for the initial two-year Management Development Program. Other employees were offered a variety of quality, cost-effective training courses to broaden and improve their job-related skills.

### Recruitment Initiatives

Confronted with increasing difficulty in attracting and retaining qualified workers, HCFA revitalized its recruitment programs in several areas. Cooperative education agreements, which provide for alternative periods of work and study for selected students, were implemented at the undergraduate level with the University of Maryland at Baltimore County, Morgan State University, the University of Miami, and Towson State University. Agreements covering graduate students were effected with Yale University and the University of Pittsburgh. HCFA recruiters appeared on campus at most of these institutions, as well as at Loyola University, Johns Hopkins University, and Western Maryland College. They also participated in various job fairs during the course of the fiscal year and conducted several specialized initiatives to identify and hire actuarial personnel. As part of the latter campaign, a special pay schedule was created to make actuarial positions more attractive to current and prospective employees.

### Presidential Management Intern Program

HCFA also turned to the nation's colleges for Presidential Management Interns (PMIs). Student-analysts enrolled at graduate schools participating in the PMI program were aggressively recruited by HCFA, as well as other Federal Government departments and agencies. And of the 200 PMIs hired by Federal entities during FY 1987, 16 were engaged by HCFA and placed in the agency's Management Development Program. They will receive training designed to prepare them to make beneficial contributions to the development and implementation of public policy.

### Employee Assistance Program

Sensitive to the need to effectively assist workers in dealing with drug and alcohol abuse, stress, family problems and other personal difficulties, HCFA procured the services of a new Employee Assistance Program (EAP) contractor and revamped the scope of EAP services. The EAP contract provides for short-term professional counseling, long-term referrals, and on-site employee and supervisory education. It is anticipated that the new EAP will provide HCFA with an effective means of assisting its employees with meeting and overcoming individual crises, thereby improving morale and productivity.

### Personnel Management Handbook for Supervisors and Managers

To guide supervisors and managers in the proper exercise of their authority, HCFA developed the Personnel Management Handbook for Supervisors and Managers in FY 1987. It provides a comprehensive explanation of HCFA's personnel policy.

## Equal Employment Opportunity Accomplishments

As in past years, HCFA pursued efforts in FY 1987 to assure equality in employment and promote affirmative action. Even though the total HCFA work force decreased during the fiscal year from 3,896 to 3,781, the percentage of women in the GS/GM 13-15 grade band increased from 25.1 to 27.5 (Table 11) and the percentage of miniorities remained unchanged at 12.2. Another 0.85 percent of the GS/GM 13-15 employees were individuals with severely handicapping conditions.

Of the 41 transitional positions maintained by the Agency in FY 1987, 15, or 36.6 percent, were assigned to minorities and one to a severely handicapped individual. Transitional positions are intended to prepare lower-graded staff for movement into higher positions through formal training and job experience.

### EQUAL EMPLOYMENT OPPORTUNITY ACCOMPLISHMENTS

| | FY 1987 | % | FY 1986 | % |
|---|---|---|---|---|
| HCFA Workforce | 3,871 | | 3,896 | |
| GS/GM 13-5 Grade Band | 1,525 | | 1,520 | |
| Minorities | 186 | 12.2 | 189 | 12.2 |
| Women | 420 | 27.5 | 381 | 25.1 |
| Severely handicapped | 13 | 0.85 | Not Available | |
| Transitional Positions | 41 | | 30 | |
| Minorities | 15 | 36.6 | 10 | 33.3 |
| Severely handicapped | 1 | 2.4 | 0 | 0 |

CHAPTER VII

# SIGNIFICANT REGULATIONS PUBLISHED IN FY 1987

## PAYMENT FOR HOME HEALTH AGENCIES

To conform with Section 9315 of OBRA, this publication revised the schedule of limits on home health agency costs effective for cost-reporting periods beginning on or after July 1, 1986, and before July 1, 1987. An updated schedule of limits for cost-reporting periods beginning on or after July 1, 1987, and before July 1, 1988, is also included.

Date of Publication: July 7, 1987

## CHANGES TO THE RETURN ON EQUITY CAPITAL PROVISIONS

This final rule conformed the regulations (with the exception of the phase-out of payments for return on equity capital for inpatient hospital services) to the provisions enacted in Public Law 99-272. For cost-reporting periods beginning on or after October 1, 1985, program payment of a return on equity capital (ROE) for SNF services and outpatient hospital services was reduced to equal the average of interest on special issues of public debt obligations issued for purchase by the Part A trust fund. For cost-reporting periods beginning on or after October 1, 1985, but before July 6, 1987, program payment of ROE for services of all non-hospital and non-SNF proprietary providers was reduced to equal the average of interest on special issues of public debt obligations issued for purchase by the Part A trust fund. For cost-reporting periods beginning on or after July 6, 1987, program payment is no longer made for ROE for services of non-hospital and non-SNF proprietary providers.

Date of Publication: June 4, 1987

## CHANGE TO THE RETURN ON EQUITY CAPITAL PROVISIONS

This publication implemented the provision in Public Law 99-272 which required a gradual reduction and eventual elimination of payments for ROE capital for inpatient hospital services. It also eliminated the allowance for a return on equity capital for outpatient services furnished by proprietary hospitals.

Date of Publication: September 1, 1987

## SCHEDULE OF LIMITS FOR SKILLED NURSING FACILITY INPATIENT ROUTINE SERVICE COSTS

This notice set forth a revised schedule of limits on skilled nursing facility inpatient routine service costs that are paid under Medicare. The schedule applies to cost reporting periods beginning October 1, 1987.

Date of Publication: October 2, 1987

## CHANGE TO THE RETURN ON EQUITY CAPITAL PROVISIONS

This rule proposed the elimination of the allowance for a return on equity capital from payment for outpatient hospital services effective for cost-reporting periods beginning on or after October 1, 1987.

Date of Publication: June 5, 1987

## ADDITIONS TO THE AMBULATORY SURGICAL CENTER COVERED PROCEDURES LIST

This rule expanded by 1,200 the number of procedures covered by Medicare when performed at an ASC. The notice resulted from review of public comments received by HCFA,as well as available claims payment data showing the actual site where procedures were performed. If the data indicated a proposed procedure was performed on an inpatient hospital basis 20 percent of the time or less, or in a physician's office 50 percent of the time or more, the procedure was not added to the ASC list. This reflected the dual legislative objectives of moving procedures from the more expensive hospital setting to the less expensive ASC setting while at the same time preventing the migration of procedures from the less expensive physicians' office settings to the ASC.

Date of Publication: April 21, 1987

## PAYMENT FOR AMBULATORY SURGERY PERFORMED BY HOSPITALS

This rule proposed regulations to implement the new payment provisions enacted under Section 9343(a) of OBRA 86 for ASC procedures performed by hospitals. The law and regulations provide that, effective for cost-reporting periods beginning on or after October 1, 1987, payment for covered ASC procedures performed in a hospital on an outpatient basis will be based, in part, on what the Medicare program pays for the same surgical procedure if performed by an approved ASC. In the past, Medicare paid hospitals for outpatient surgical procedures on the basis of the hospital's reasonable costs or customary charges, whichever were lower. Under the new payment method, aggregate payment to hospitals for facility services furnished in connection with ASC procedures will be based on: (1) the hospital's reasonable costs or its customary charges, whichever are less, or (2) a blended amount consisting of 75 percent of the hospital's reasonable costs or customary charges, whichever are less, and 25 percent of the amount that would be paid to an ASC for performing the same surgical procedures. For cost-reporting periods beginning on or after October 1, 1988, the blended amount is based on 50 percent of the hospital's costs or charges, whichever are less, and 50 percent of the ASC payment amount.

Date of Publication: June 2, 1987

## USER FEES FOR FEDERALLY QUALIFIED HMOs

This rule requires HMOs seeking Federal qualification under Title XIII of the Public Health Service (PHS) Act to submit a fee with their applications for initial qualification of expansion. The purpose of the fee is to cover HCFA's administrative costs incurred in making these determinations. The fee is $18,400 for an HMO seeking initial qualification, and the same amount for an HMO seeking separate qualification as an HMO of a regional

component. HCFA will return $8,000 of this fee if a site visit is determined to be unnecessary. The fees are $6,900 for an HMO seeking expansion of its service area, and $3,100 for a CMP which wants also to quality as federally qualified HMOs under Title XIII of the PHS Act.

Date of Publication: June 11, 1987

## CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) OF 1985 CHANGES RELATED TO HMOs

HCFA published a final rule with a comment period to implement provisions of Section 9211(a), (b), and (c) of Public Law 99-272, COBRA. These regulations establish procedures for paying for a hospital stay when an inpatient of hospital subject to the PPS enrolls or disenrolls from an HMO or CMP contracting on a risk basis during the stay. The rule also requires HMOs and CMPs to submit marketing materials intended for Medicare beneficiaries to HCFA for review prior to their use. The rule further eliminates the period of one full calendar month between a request to disenroll and the effective date of disenrollment and requires a written explanation to disenrolling beneficiaries of exactly when their enrollment ends. No comments were received that necessitated revisions in the regulation and it became effective April 20, 1987.

Date of Publication: March 20, 1987

Chapter VIII

# REPORTS AND PUBLICATIONS

HCFA publishes a variety of reports and publications dealing with the Medicare program. Those publications listed in this chapter may be of particular interest to the Congress as well as to the public.

## ORDERING INFORMATION

Except where noted, single copies of the following beneficiary publications are available from local Social Security Administration offices or by written request to:

Health Care Financing Administration
Office of Public Affairs (OPA)
Room 658 East High Rise Building
6325 Security Boulevard
Baltimore, Maryland 21207

Research and Demonstrations (R&D)—To be placed on the mailing list for notification of all R&D reports as they are published and to obtain single complimentary copies of publications, with the exception of the HCFA Review, write to:

Health Care Financing Administration
Office of Research and Demonstrations (ORD)
Publications and Information Resources
Room 1-A-9 Oak Meadows Building
6340 Security Boulevard
Baltimore, Maryland 21207

***What You Should Know About Medicare*** (ICN 460000, SSA-05-10043, January 1987). A pamphlet describing the basic aspects of Medicare including coverage, deductibles, coinsurance and eligibility requirements.

***Your Medicare Handbook*** (ICN 000181, HCFA-10050). A comprehensive explanation of the Medicare program for Medicare beneficiaries.

***Guide to Health Insurance for People with Medicare*** (ICN 487790, HCFA-02110, 1987). A consumer-oriented pamphlet for Medicare beneficiaries that discusses what Medicare pays and does not pay, types of private health insurance to supplement Medicare, and what to look for when shopping for private health insurance.

***Medicare and Employer Health Plans*** (ICN 488331, HCFA 02150, 1986). The pamphlet explains the law which requires employers to offer employed Medicare beneficiaries age 65 or older the same health insurance plan that they offer to their younger employees.

***Medicare and Prepayment Plans*** (488339, HCFA 02150, 1986). A pamphlet describing kinds of HMOs and what health services they offer.

***Your Hospital Stay Under Medicare's Prospective Payment System*** (PPS) (ICN 488334, HCFA 02150, 1986). A pamphlet describing the Prospective Payment System, Diagnosis Related Groups (DRGs) and Peer Review Organizations (PROs).

***Hospice Benefits Under Medicare*** (ICN 487973, HCFA-02154, 1986). A pamphlet describing the special rules of coverage for care in a hospice program.

***Beneficios de Hospicio Bajo Medicare*** (ICN 488332, HCFA 02162, 1986). A Spanish version of Hospice Benefits Under Medicare.

***Thinking of Having Surgery? Think About Getting A Second Opinion*** (ICN 487793, HCFA-02114, 1982). A brochure addressing the advisability of seeking a second medical opinion before agreeing to any non-emergency surgery. It outlines questions you should ask, when to get a second opinion, how to find a specialist to give a second opinion, and how to pay for a second opinion.

***Medicare and You*** (ICN 443504, HCFA 00009, 1987). Scriptographic booklet. This booklet explains what Medicare is, what it covers and pays, and how to qualify for Medicare.

***Report on Hospital Wage Index*** (HCFA, March 1985). This report describes the differences in wages from area to area by the labor-related portion of the Federal prospective payment rates. The report also contains the results of the HCFA wages survey and two new wage indexes based on that survey. (Available from NTIS.)

***Medicare and Medicaid (There is a Difference!)*** (ICN 443514, HCFA 0019, 1987). Scriptographic booklet. This booklet explains the difference between Medicare (an insurance program) and Medicaid (an assistance program).

***Health Status of Aged Medicare Beneficiaries*** This report provides descriptive information from the National Medical Care Utilization and Expenditure Survey about selected aspects of the health status of noninstitutionalized elderly people covered by Medicare, including measures of disability, activity limitation, illness conditions, and perceived health status. (Available from ORD.)

***Access to Health Care Among Aged Medicare Beneficiaries*** This report provides descriptive information from the National Medical Care Utilization and Expenditure Survey about selected aspects of access to health care among noninstitutionalized elderly people covered by Medicare, including regular source of care, physical access to the regular source, insurance coverage, and the existence of medically unattended conditions. (Available from ORD).

Several publications series covering research and demonstration activities and statistical information on the Medicare and Medicaid programs were part of a dissemination effort to reach interested user groups and to provide research results for policymakers and health professionals.

***Health Care Financing Program*** **(Brown Series).** Provides detailed information on Medicare and Medicaid program operation and use, including data on enrollment, utilization, providers, reimbursement, and recipients.

***Health Care Financing Research Reports* (Purple Series).** Reports on major intramural studies and projects conducted by HCFA. Contain significant findings that affect HCFA programs and serve as a basis for making program changes.

***Health Care Financing Grants and Contracts Reports* (Blue Series).** Final reports of extramural projects funded by HCFA/ORD. Topics include hospital cost containment, long-term care reform, physician reimbursement, beneficiary access to and use of services, and health systems organizations.

***National Medical Care Utilization and Expenditure Survey Reports* (Rust Series).** Reports on the survey findings, including information on access to and use of medical care, health and demographic characteristics of persons and families, and the sources and costs of services.

***Health Care Financing Special Reports* (Orange Series).** Report on single themes, providing comprehensive coverage of an important issue in health care financing.

***Status Report: Research and Demonstrations Health Care Financing* (Red Series).** Provide basic information in a brief format on the more than 300 intramural and extramural projects conducted by HCFA/ORD to examine program expenditures as they relate to reimbursement, coverage, eligibility and management alternatives under Medicare and Medicaid.

***Health Care Financing Notes* (Black on White Series).** Brief and concise reports that present data highlights on various aspects of the Medicare and Medicaid programs. Health Care Financing Project Reports (Black on Buff Series). Include brief reports on individual research and demonstration projects that provide an overview of the project and major findings or results and include information on obtaining related publications.

***Health Care Financing Review* (Green Quarterly Plus Annual Supplement).** HCFA's quarterly research journal, reports findings related to health care financing. Includes trends data that highlight economic developments in the health care sector and announcements of new HCFA research publications and projects.

Additional information on the research publications program and the availability of various reports may be obtained from the ORD Publications and Information Resources Branch, Room 1-A-9 Oak Meadows Building, 6340 Security Boulevard, Baltimore, Maryland 21207.

Other publications and technical manuals are available for a fee by writing or phoning:

National Technical Information Services (NTIS)
Document Sales
5285 Port Royal Road
Springfield, Virginia 22151
Telephone: (703) 487-4650 (Document Sales)
(703) 487-5600 (General Information)

Chapter IX

# FISCAL YEAR 1987

Report on Medicare Validation Surveys of
Hospitals Accredited by the Joint Commission
on Accreditation of Healthcare Organizations
(Joint Commission)

## Introduction

The purpose of the validation program is to evaluate the effectiveness of the Joint Commission accreditation process in providing reasonable assurance that hospitals comply with the intent of the Medicare conditions of participation. Each year HCFA selects a statistical sample from the approximately 5,100 accredited hospitals for validation surveys. Under contract with the Secretary, State agencies (SAs) conducted 61 validation surveys during FY 1987.

### Statutory Background

Section 1865 of the Social Security Act (the Act) provides that accredited hospitals are deemed to meet the requirements of the Medicare conditions of participation and are not subject to annual SA surveys to assess compliance with the conditions of participation. Subsection 1864(c) of the Act, however, authorizes the Secretary to enter into an agreement with any State to survey hospitals accredited by the Joint Commission on a selective sample basis or in response to substantial allegations of significant deficiencies that affect the health and safety of patients.

### Accreditation Process

The accreditation survey assesses a hospital's compliance with the Joint Commission standards. After the completion of the on-site survey, the Joint Commission makes an accreditation decision. Under the accreditation program, a hospital may receive a 3-year accreditation, with or without a contingency, or in cases where a hospital fails to achieve substantial overall compliance, no accreditation. A contingency stipulates that the accreditation will be withdrawn if the hospital fails to correct its deficiencies within a specified amount of time. The Joint Commission, through the use of focused on-site resurveys and/or written reports prepared by the hospital, determines whether the hospital has corrected the deficiencies necessary to retain accreditation. The contingency accreditation process is analogous to a Medicare/Medicaid resurvey as they both assess correction of deficiencies. If corrections are not completed as specified in the contingency, the accreditation may be withdrawn.

### Validation and Allegation Process

HCFA selects, from scheduled accreditation surveys, a statistical sample of accredited hospitals for validation surveys. The random selection reflects the urban-rural mix and the range of different sizes of participating hospitals. This permits the application of HCFA's findings to the universe of accredited hospitals. SAs survey these hospitals using the Medicare conditions of participation for hospitals.

In addition to the sample surveys, an accredited hospital is also subject to a SA survey when there is an allegation that significant deficiencies threaten the health and safety of patients. Allegation surveys evaluate only the specified condition(s) as authorized by HCFA's regional offices. If the SA finds a significant deficiency in the specified condition(s), the investigation is expanded to a full survey.

In both sample and allegation surveys, if the SA finds significant deficiencies, the hospital is placed under SA surveillance until the deficiencies are corrected. The hospital is no longer deemed to meet the Medicare conditions of participation and the SA monitors the correction of any deficiency as if the hospital were unaccredited.

In this report period the Joint Commission made 1,958 accreditation decisions for hospitals. Of that number, 41 were awarded three-year accreditations without contingencies, 1,302 received accreditations requiring written contingency reports, 105 received accreditations requiring contingency onsite visits and 503 received contingencies requiring both written reports and onsite visits. One hospital received a consultation and education visit, four were nonaccredited (three have appealed the decision), and two were tentatively nonaccredited.

## Findings of FY 1987

### Sample Validation Surveys

#### Life Safety Code

The Life Safety Code (LSC) of the National Fire Protection Association, a consensus standard adopted by reference in Federal regulations, provides a reasonable level of safety from fire and other emergencies. LSC for fire safety has been the most difficult requirement for both accredited and nonaccredited hospitals to meet. During this reporting period, 9 of the 61 hospitals receiving validation surveys failed to comply with the LSC. Two of them were out of compliance with the LSC and one or more general health and safety conditions (Table 15). For all hospitals receiving validation surveys prior to this reporting period, 446 of 927, or 48 percent, were not in compliance with the LSC.

This increase in LSC compliance can be attributed to the Joint Commission's adoption of the Fire Safety Evaluation System (FSES). The FSES was developed by the National Bureau of Standards to permit a health care facility to employ alternative measures for meeting the LSC requirements while providing an equivalent level of fire safety. The Joint Commission and Medicare LSC surveyors both use the FSES.

In previous years, the Joint Commission surveyors were not citing smoke barrier deficiencies. On HCFA's recommendation, the Joint Commission focused their training efforts on the LSC smoke barrier requirements and significantly increased the comparability of the accreditation and Medicare/Medicaid findings in that area. The Joint Commission reports also cited several deficiencies in heating, ventilating and air conditioning systems, these also had occasionally been overlooked in the past. In general, however, Joint Commission surveys, which observed a lack of maintenance and testing in some facilities, cited them for a lack of documentation rather than for lack of proper operation. When similar items were cited by HCFA, the items were cited for lack of proper operation and not for lack of documentation.

As a result, HCFA surveyors cited many more LSC deficiencies than did the Joint Commission surveyors. HCFA informed the Joint Commission that it believes that the quantity and quality of the Joint Commission deficiencies citations could be improved to provide a better level of safety if Joint Commission surveyors devoted more attention to the facilities physical environment when surveying for the LSC requirements.

**General Health and Safety**

On September 15, 1986, the revised Medicare conditions of participation for hospitals became effective. These regulations simplify and clarify Federal requirements. They provide flexibility in hospital administration while strengthening patient health and safety, emphasize outcomes rather than processes, promote cost-effectiveness while maintaining quality of care, and provide a more effective tool for enforcing compliance with Federal requirements.

During this reporting period 15 of 61 hospitalsvalidation surveys failed to comply with one or more general health and safety conditions. Eight of the 15 were out of compliance with 1 condition, 4 were out with 2 conditions and 1 each were out of compliance with 4, 5 and 12 conditions of participation. For all hospitals receiving validation surveys prior to this reporting period, 231 of 927, or 25 percent, were not in compliance with the general health and safety conditions.

Six hospitals (10 percent) were cited for infection control during the period. This is a new requirement that became effective September 15, 1986, and was reported on last year. Comparing the Joint Commission and HCFA survey findings, they frequently found the same deficiencies. The Joint Commission surveyors' approach to problems differed, however, as they tended to concentrate on infection control policy and the role of the hospital organization in controlling infection. They would then make recommendations for correction. HCFA surveyors, on the other hand, cited the condition as out of compliance, which had the effect of prompting the hospital to make a timely correction if it desired to remain in the program.

Laboratory services ranked next with 5 hospitals found out of compliance (Table 16). Laboratory Services had the highest general health and safety frequency of non-compliance last year as well, with non-compliance frequencies of 8 percent for accredited sample hospitals and 6 percent for unaccredited hospitals.

The Joint Commission accepts accreditation of a laboratory by the College of American Pathologists (CAP) in lieu of its own survey in about 40 percent of its hospitals. The remainder are surveyed as a part of the Joint Commission accreditation process. At this time, HCFA does not have access to CAP findings, although the agency has asked the Joint Commission to start providing the findings.

Two hospitals had laboratory service deficiencies cited by the SA related to the "frequency of quality control samples." These were not noted by the Joint Commission. HCFA is revising its policy on the frequency of quality control samples and this will have the effect of eliminating some of the differences between the Joint Commission and the Medicare/Medicaid quality control requirements.

In summary, 22 hospitals that received sample validation surveys were found out of compliance with at least one general health and safety condition of participation and/or the LSC.

## Complaint Investigation Findings

For this report period, SAs investigated complaints at 606 hospitals based on allegations of significant deficiencies that could affect the health and safety of patients. HCFA found 9 percent (52 of 606) out of compliance with one or more conditions. In FY 1986 HCFA found 11 percent (45 of 402) out of compliance. There were half again as many allegations in FY 1987 as in FY 1986, but only a small drop in the percent out of compliance. Over the years the nature of complaints and the percent of complaints substantiated remains relatively constant.

## Conclusion

Complaint investigations of 606 hospitals indicated that only 9 percent were out of compliance. However, the full validation surveys of 61 hospitals found 36 percent not in compliance with major health and safety requirements. Because of the small sample size involved for validation surveys, it is impossible to determine the significance of the percentage of hospitals out of compliance. The high percentage prompted HCFA to increase the size of the sample in 1988 and thereafter so that one may come to reliable, valid conclusions about the performance of hospitals accredited by the Joint Commission and the comparability of the Joint Commission's accreditation program with the Medicare/Medicaid survey and certification program. In FY 1988 HCFA will conduct approximately 100 (2.5 percent) validation surveys and increase this number to approximately 200 (5 percent) in FY 1989.

### LIFE SAFETY CODE AND GENERAL HEALTH SAFETY

### FY 1987 SAMPLE NONCOMPLIANCE COMPARED TO ALL PREVIOUS REPORTS

**Sample Validation Survey Noncompliance**

| Reasons for Noncompliance | All Previous Report Periods | | FY 1987 | |
|---|---|---|---|---|
| | Number | Percent | Number | Percent |
| Hospitals Out of Compliance with Life Safety Code Only | 292 | 31% | 7 | 11% |
| Hospitals Out of Compliance with LifeSafety Code and at Least One General Health and Safety Condition of Participation | 154 | 17% | 2 | 3% |
| Hospitals Out of Compliance with General Health and Safety Condition(s) of Participation Only | 77 | 8% | 13 | 21% |
| Total Noncompliance | 523 | 56% | 21 | 34% |
| Total Surveys | 927 | 100% | 61 | 100% |

## FY 1987 SAMPLE NONCOMPLIANCE COMPARED TO UNACCREDITED UNIVERSE NONCOMPLIANCE BY CONDITION

| Condition | Sample (58 Hospitals) Noncompliance Frequency | % | Unaccredited Universe (1406 Hospitals) Noncompliance Frequency | % |
|---|---|---|---|---|
| State and Local Law | 2 | 3 | 48 | 3 |
| Governing Body | 3 | 5 | 45 | 3 |
| Quality Assurance | 4 | 7 | 55 | 4 |
| Medical Staff | 2 | 3 | 37 | 3 |
| Nursing Services | 2 | 3 | 55 | 4 |
| Medical Records Service | 3 | 5 | 36 | 3 |
| Pharmaceutical Services | 2 | 3 | 51 | 4 |
| Radiologic Services | 1 | 2 | 14 | 1 |
| Laboratory Service | 5 | 8 | 60 | 4 |
| Food and Dietetic Service | 2 | 3 | 29 | 2 |
| Physical Environment | 2 | 3 | 48 | 3 |
| Infection Control | 5 | 8 | 51 | 4 |
| Optional Services: | | | | |
| Surgical Services | 2 | 3 | 13 | 1 |
| Anesthesia Services | 1 | 2 | 17 | 1 |
| Nuclear Medicine Services | 0 | 0 | 3 | 1 |
| Outpatient Services | 1 | 2 | 11 | 1 |
| Emergency Services | 1 | 2 | 40 | 3 |
| Rehabilitation Services | 1 | 2 | 9 | 1 |
| Respiratory Care Services | 1 | 2 | 17 | 1 |

Chapter X

# MEDIGAP VOLUNTARY CERTIFICATION PROGRAM REPORT

(Section 1882(f)(2) of Title XVIII)

## Introduction

Congressional studies conducted prior to 1980 found many abuses in the sale and marketing of Medicare supplement or "Medigap" health insurance. There were no Federal standards for Medicare supplement coverage and few States had adopted programs specifically to regulate these types of policies. In June 1980, Congress enacted Public Law 96-265, which added Section 1882 to Title XVIII of the Social Security Act. This law, usually referred to as the Medigap law, initially was opposed by insurance regulators and the insurance industry. The regulation of the business of insurance had traditionally been the responsibility of the States under the McCarran-Ferguson Act of 1945, and the Medigap law was perceived by some as an encroachment upon States' rights. This perception resulted from a fear that the Federal Government would necessarily become greatly involved in individual insurance department operations in order to enforce the law. This has not proved to be the case, however, and the relationship between the Federal Government and the States has been a cooperative one. State and Federal agencies are working together toward the common goal of providing the best protection available for elderly citizens.

## Provisions of Medigap Law

The Medigap law established Federal minimum standards based primarily on the provisions contained in the 1979 National Association of Insurance Commissioners (NAIC) Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act. The law, however, expands upon the model's requirements by extending its jurisdiction to certain group policies and by adding loss-ratio requirements for both group and individual policies. In addition, it provides for the establishment of the Supplemental Health Insurance Panel and a Federal Voluntary Certification Program for Medicare supplement policies. It also includes criminal penalty provisions for certain abusive sales practices.

The law further requires the Secretary of HHS to submit to Congress no later than July 1, 1982, and periodically as may be appropriate thereafter (but not less than once every 2 years), a report evaluating the effectiveness of the certification procedure and the criminal penalties established under this section.*

* On March 3, 1987, the Department of Health and Human Services issued a Report to Congress: Study of Health Insurance Designed to Supplement Medicare and Other Limited Benefit Health Insurance Sold to Medicare Beneficiaries. That report, mandated by Section 507(f) of Public Law 96-265, studies the comparative effectiveness of various State aproach- es in the regulation of Medicare supplement policies. It explored three issues: (1) whether there is a need for mandatory Federal regulatory program; (2) whether there is a need for standards for health insurance policies other than Medicare supplements sold to Medicare beneficiaries; and (3) whether there are other appropriate means that would enhance effective State regulation of Medicare supplement policies. The report concluded that there is no need for a mandatory Federal program and recommended that States should be encouraged to adopt appropriate minimum benefit standards for private health insurance sold to Medicare beneficiaries and to adopt several actions to enhance effective State regulation of Medicare supplement policies.

### The Voluntary Certification Program

Under the Voluntary Certification Program insurers selling Medigap policies in a State that has not adopted the Federal standards as part of its regulatory program may voluntarily submit such policies to be reviewed by the Secretary of HHS. Those policies found to meet or exceed the Federal minimum standards will be certified, and the insurer will be authorized to display a Federal emblem on the policy. The emblem is authorized for use only in States subject to the Federal program, regardless of whether the same policy is marketed in States not under the program.

### Participation

The Supplemental Health Insurance Panel determined that the Voluntary Certification Program should be implemented in four states — Massachusetts, New York, Rhode Island, and Wyoming — and three U.S. territories: Guam, the Virgin Islands, and American Samoa.

Only two insurers have submitted policies for review under the Voluntary Certification Program, and no policies have been certified to date. Although the deficiencies noted in the policies submitted were seemingly minor, the insurance companies involved have not resubmitted the policies, nor indicated that they have made the necessary changes. The fact that the Voluntary Certification Program applies only to a very few States and jurisdictions in itself limits the program's direct inpact.

In this same respect, however, the Voluntary Certification Program was responsible for the overwhelming success of the Medigap law, since it served as an incentive for such a large number of States to adopt their own programs regulating Medigap policies. Indeed, the number of States adopting the 1979 NAIC model is the largest ever to adopt any NAIC model. In addition to the small number of States involved, there are other possible reasons for such a limited reaction to the program. Foremost is the perception on the part of the State insurance regulators and the insurance industry that such a program is an infringement upon the individual State's right to regulate the business of insurance. As noted earlier, the Federal-State relationship resulting from the Medigap law has proved an amiable one, but there is still much apprehension in the insurance community about a "Federal" emblem being placed on private insurance policy. It is felt that the emblem may encourage the practice of "twisting," whereby insurance agents replace existing coverage with new coverage that offers no greater benefits or even lower overall benefit levels. Some insurers also feel that the emblem may confuse some elderly Medicare beneficiaries, since it may appear only on those policies sold in States subject to the Voluntary Certification Program.

Most insurers design their Medigap policies to be marketed in a number of States. Thus, a situation would exist whereby a policy would be able to display the emblem in a State under the Federal program, but the exact same policy could not bear the emblem in a State that was not under the program. The additional cost involved in preparing policies for distribution in just a few States also is a deterrent to seeking certification.

### Impact

Since the Secretary has not yet certified any policies under the Voluntary Certification Program, there is no data available to show the direct impact of the certification procedure on market share, value, and cost to individuals entitled to benefits under Title XVIII. As stated earlier, however, the indirect impact of the program has been its positive effect of

prompting States to implement their own approved regulatory programs for Medicare supplement policies. Without the incentive provided by the Voluntary Certification Program, it is doubtful that as many States would have changed their programs. Also, the Supplemental Health Insurance Panel is now responsible for monitoring the continued compliance of the approved States, and the Voluntary Certification Program should act as a deterrent to those States considering changes to their regulatory programs that would adversely affect their continued compliance with the Medigap law.

The Medigap law also established Federal criminal penalties for certain fraudulent or abusive marketing practices. Section 1882(d) provides criminal sanctions for furnishing false or misleading information for the purpose of obtaining certification; for misrepresentation as an agent of the Federal Government for the purpose of selling insurance to supplement Medicare; for knowingly selling insurance which substantially duplicates benefits of another policy held by the purchaser; and for knowingly advertising, soliciting, or offering for sale mail-order policies in a State without the approval of the State insurance commissioner. Anyone convicted of violations of Section 1882 is subject to a fine of up to $25,000 and/or imprisonment for up to 5 years.

**Implementation**

HCFA, given the responsibility for implementing the penalty provisions of the Medigap law, continues to investigate possible violations of Section 1882(d). The agency has developed a coordinated system for reporting these violations that includes the 10 HCFA regional offices, the SSA, HHS OIG, and the Department of Justice (DOJ).

The initial screening of complaints is generally done through HCFA's regional offices. These offices are also responsible for furnishing information to State insurance departments about specific complaints. The OIG investigates complaints that have been referred to it by HCFA and coordinates this activity with State insurance departments. The OIG also serves as the liaison between State insurance departments and U.S. Attorneys, who have been contacted by the Fraud Divison of the DOJ regarding the Medigap law and encouraged to prosecute violations of this section.

HCFA also receives occasional complaints about practices which, while not in violation of the Medigap law, are possible violations of other Federal statutes. These most often involve misleading advertising and mail order solicitations for Medicare supplement insurance. HCFA's efforts in this area are coordinated with other Federal agencies such as the Federal Trade Commission and the Postal Inspection Service.

**Activity in Fiscal Years 1986 and 1987**

HCFA continued to investigate potential violations of Section 1882(d) of the Medigap law and was notified of 20 possible violations in FY 1986 and 9 in FY 1987. All of these cases were closed out due to either a lack of evidence or to referral to specific State insurance departments for investigation of possible violations of State laws. Additionally, three cases pending from prior fiscal years were closed out. Concerning compliance of State regulatory programs, all of the States originally granted Panel approval were recertified to ensure that they continue to maintain programs that meet the Federal minimum standards. HCFA also continues to respond to public and congressional inquires regarding Medicare supplement insurance, and in FY 1986 prepared a detailed packet of information on the Medigap program and submitted it to the Honorable Claude Pepper, Chairman, Subcommittee on Health and Long Term Care, Select Committee on Aging.

### Difficulties in Prosecution

Witness reliability has continued to be a problem in getting cases prosecuted under Section 1882. The elderly often become confused under questioning, and prosecutors are reluctant to charge agents under Federal law, since criminal penalties are indicated. They believe that administrative penalties would be more appropriate in many cases.

There remains interest at the State level in utilizing Federal penalties to prevent abuse and fraud in the sales and marketing of Medigap policies. Most States still do not have specific laws for violations involving Medicare supplement health insurance. As indicated, however, getting these types of cases prosecuted under Federal law has proved difficult, and there have been no convictions to date under this law. At the present time it is believed that it is in the best interest of elderly citizens to continue the penalty provisions of Section 1882 to keep available the option of prosecution under Federal law.



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